S. HRG. 103-477

THE HEALTH-CARE CRISIS IN AMERICA TODAY

HEARINGS

BEFORE THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

SEPTEMBER 14 AND 15, 1993

Printed for the use of the Joint Economic Committee

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SUBMISSIONS FOR THE RECORD

THE HEALTH-CARE CRISIS IN AMERICA TODAY: A GROWING THREAT TO ECONOMIC SECURITY

TUESDAY, SEPTEMBER 14, 1993

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in room 2359, Rayburn House Office Building, Honorable David R. Obey (Chairman of the Committee) presiding.

Present: Representatives Obey, Cox and Ramstad.

Also present: Richard McGahey, Executive Director; David Podoff; Morgan Reynolds and Lawrence Hunter, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE OBEY, CHAIRMAN

REPRESENTATIVE OBEY. Good morning.

Before we begin, I would like to make an announcement, in light of the success that Norway had yesterday in bringing Israel and the PLO together. Gro Brundtland, the Prime Minister of Norway, has announced that she is willing to mediate the health-care dispute between the Democratic and Republican parties in Washington. We want her to follow on in a second effort.

We are here this morning because the Congress, the President, the Country and everybody with an interest in it, intellectual or financial, are about to tackle the biggest domestic problem since social security: The reform of the Nation's health-care system.

Next week, the President will be presenting his plan to a joint session of Congress. Congress will then be engaging in a substantive, complex and important debate.

I think everybody knows that true, comprehensive health-care reform will be contentious and complex. It seems to me that before we debate and enact such far-reaching legislation, it would be helpful if we could do our best to reach a common understanding of the problems that exist within the health-care system today.

The hearings that we will be conducting today and tomorrow will examine the health-care crisis and its impact on the economy. Witnesses will be discussing the current system, how it got that way, and what the consequences will be of sticking with the status quo.

These hearings are not for the purpose of debating the Administration's reform plan which, despite all the information in the press, is still subject to change. And I am old-fashioned enough to believe that you ought to have, if you are going to have a hearing, a product before you when you hold that hearing. I am also old-fashioned enough to believe that if you can reach a common understanding of the problems, as they exit today, you have a better chance of reaching a rational, bipartisan conclusion about what the solutions are for tomorrow.

Why hold hearings now? I think simply that it is important before all the guns begin firing, as if they have not already, that we lay out the dimensions of the crisis and what it is doing to our economy and our people.

Many members of Congress and many experts have been looking at these issues in minute detail, but the American public still has not been fully engaged in the debate. And they will. Unlike the budget, for instance, where I think you have marginal attention being paid by the public to the details of the budget debate, because the average citizen does not deal with the federal budget every day—he is too busy making a living—every single American deals with health care on virtually a monthly basis.

So I think they have an in-depth understanding of what they face. I am not so sure they have a clear understanding of what forces are at work that cause some of the problems they face. I am certain they do not have an understanding of what anybody is planning to do in order to try and deal with the problem.

So we are here to ask questions, not to rush to prepackaged and predetermined answers. These hearings are for the purpose of examining the situation as it exists today, not debating what is going to happen tomorrow until we see the alternatives before us in order to deal with tomorrow.

To explore the issues, we will have three panels, one today and two tomorrow. Our witnesses include experts in economics, medical care and insurance. We will also hear about how the health-care crisis affects ordinary Americans, working Americans, families and senior citizens. The challenge facing us is daunting when you consider the facts. Health-care costs are about 14 percent of America's gross domestic product annually, compared to less than 10 percent in any other nation. Health-care costs are expected to rise to almost 20 percent of GDP by the year 2000. Health insurance is eating up an ever-larger amount of wages and payroll, and that is projected to almost double by the year 2000.

Health-care spending is going more and more to administrative spending and not to medical care. Almost two thirds of real projected growth in federal spending will go to health care, crowding out investments in areas such as education, infrastructure, job training, and despite the fact that a lot of the debate is going to be about health insurance and how you pay health insurance premiums. The fact is that American families today, even with the insurance system in place, pay about two thirds of the cost of health coverage in this country. And yet, inspite of all this, there are roughly 37 million Americans who are without health insurance, and one in four will lose their coverage at some time during the next two years.

Like most members of Congress, I have some pretty strong views personally about health care, but frankly, I don't think many people are interested in my views or the views from this side of the table. We will have a long time to debate the issue once the different alternatives are sent down to us.

So I would ask each of our witnesses to focus on a few critical questions: Is the American health system really broken? If it is, to what extent? What factors have contributed to the current crisis? Why is and why should reform be on the agenda now? What will the consequences be of sticking with the status quo? do we need wholesale reform, or can incremental changes do the job that is required? and in that process, I think, gentlemen, you will help us all

to begin the process of trying to reach a common conclusion on the issue, even if it, in the end, winds up not being a unanimous conclusion.

We have before us today Paul Starr, Professor of Sociology at Princeton University; John E. Wennberg, M.D., Director, Center for Evaluative Clinical Sciences, Dartmouth Medical School, Merrill Matthews, Director, Center for Health Policy Studies, National Center for Policy Analysis; and Allen Feezor, M.A., Chief Deputy, North Carolina Insurance Commission.

Before we begin, I would like to have entered into the record a letter from Ms. Tyson, Chairman of the the President's Council of Economic Advisers. She unregretably was unable to appear as a witness at today's hearing. I would also like to enter into the record the written opening statements of Senator Craig and Congressman Ramstad.

[Letter from The Honorable Ms. Tyson starts on p.46 of Submissions for the Record; the written opening statements of Senator Craig and Representative Ramstad start on p.47 and p.50, respectively, of Submissions for the Record:]

Gentlemen, why don't we begin with Mr. Starr, and why don't each of you take whatever reasonable amount of time you think is necessary to give us your view of the health-care situation as it exists today.

STATEMENT OF PAUL STARR, PROFESSOR OF SOCIOLOGY, PRINCETON UNIVERSITY

MR. STARR. Thank you. It is an honor to participate in the kickoff hearing this fall season for what promises to be a great and historic national debate.

Health-care reform has become the precondition for achieving many of our most important national objectives. I think that applies almost regardless of your political point of view. If you want to control the federal deficit, you need health-care reform. If you want to raise wages for American workers, you need health-care reform. If you want to improve security for American families, you need health-care reform.

The facts are, I think, striking, One out of every four Americans under age 65 loses health insurance coverage every two-year period. so the sense of insecurity about health-care costs extends far beyond the 37 million Americans who are uninsured at any one time.

Costs are rising at absolutely astonishing rates. Since 1980, the health-care sector has gobbled up an additional 1 percent of the gross domestic product every 35 months. This is an unsustainable rate. It is unparalleled anywhere else in the world.

We are now, as you mentioned Mr. Chairman, at 14 percent; we are headed towards 17 percent. The average in industrialized countries is now 7.9 percent. If you ran a business and were running costs so much higher than your competitors, you would say, something is wrong, we have to change. and, of course, these higher costs to the Nation naturally mean higher costs to business; they mean higher costs to individuals.

In 1991, health services cost Americans an average of $2,868 per person. The Germans only spent $1,659, and most people believe that the Germans have a pretty good health-care system. Of current spending in the United States, between 20 and 30 percent, according to a variety of studies, is estimated to be unnecessary.

I think that if we believe our spending for health care was being spent well, these high numbers might not concern us. But there is abundant evidence

capacity in hospitals, misallocation of physicians among specialties, and much unnecessary investment in equipment.

But for many Americans, the health-care problem isn't a matter of numbers and abstractions like these. It is just the story of their lives. It is the story of the family that loses its coverage when the husband's company downsizes and his job vanishes. It is the story of the young woman who would like to quit her job and start a company of her own, but she can't. With her history of cancer, she would never get any health insurance. It is a story of the single parent on welfare who would like to take a paying job, but is she takes that job, she will have no health benefits and her son has chronic asthma.

It is the story of millions of small business owners who want to buy health insurance for themselves, for their families, for their employees, for their children, but they can't get coverage at an affordable price. It is the story also of our biggest corporations loaded down under huge extra burdens, a big cost shift from the uninsured as hospitals recoup uncompensated care costs, and ballooning costs for the company's own early retirees.

The health-care crisis is also the story of everybody in public life. It is the story of governors who don't have enough money for public infrastructure and other needs, because every year Medicaid eats up discretionary funds. And I would say that it is even the story of this Congress. People here would like to cut the deficit or cut taxes, but are stymied by the prospect of rising health-care costs that threaten our Nation's solvency.

So all of us, regardless of political persuasion, need change in health care. For some, their health is at stake. For others, their peace of mind is at stake. For all of us, our national economic interest is at stake.

But to be able to break the cycle of rising costs and eroding security, we have to have an understanding of what is driving this problem. We have to understand the systemic sources of high health-care cost and health insecurity in the United States.

I think two aspects of the problem especially demand our attention. One has to do with the evolution of health insurance in recent decades, as the industry has segmented Americans into risk groups, and denied coverage to many people who were just thought to be high risk. Health insurance used to spread risk. Increasingly health insurers have sought to avoid risk. And the industry's efforts to avoid risk rather than control costs have been at the root of growing insecurity about health care. Reform has to reverse this pattern. It has to encourage health plans to control costs and give their members the best value for their money, rather than screening out risky people.

A second aspect of the problem concerns the incentives facing doctors, patients and managers of health-care organizations. Incentives favoring high costs have long been built into our system, and we haven't had any effective countervailing force. And that imbalance is critical to understanding why costs have exploded in the United States.

Reform has to correct that imbalance. It has to create the incentives for value-conscious choices and the countervailing pressure to keep costs down.

Even the term "health insurance" has become a misnomer. One of my colleagues refers to our system as "health unsurance" in the United States. When private health insurance first developed back in the 1930s and 1940s, the original Blue Cross and Blue Shield plans adopted a system called

"community rating." They offered coverage to employee groups at the same premium, the same community rate.

But over the years the industry changed. Commercial health insurance companies picked off many of the younger, lower-risk employee groups, and gradually, Blue Cross was forced to adapt, forced to adapt this alternative system of experience-rating. So the system of experience-rating made it increasingly difficult for insurers to offer affordable coverage to groups that predictably experience high-medical costs.

In 1965, we took care of part of that problem with the adoption of Medicare and Medicaid. But still, millions of other Americans could qualify for neither those government programs nor for favorable private group rates. They were stuck in the individual and small group markets, stuck with very high rates for the kind of coverage offered to them.

In recent years, this pattern has only gotten worse. It has gotten worse as health-care costs have risen and health insurers have responded by introducing a series of practices, like exclusions for preexisting conditions, redlining of occupations and industries; refusals to renew coverage for groups that experience high claims and a variety of subtle rating practices that effectively drive the sickest people out of the risk pools and deny them coverage.

Illness can strike any of us at any time. That is why we need insurance. But the insurance system today often penalizes many of us for the misfortune of ill health. The system denies affordable coverage to people who desperately need it. It may exclude us even if we are healthy, but happen to work in an occupation thought to be above average in risk.

The term "insurance" is supposed to convey peace of mind, but health insurance in this country has ceased to be insurance, in the full sense of that word.

Now, this problem in the health insurance industry was aggravated by the steady growth in health-care costs through the 1970s and 1980s, a development which was the product, I think, of two aspects of our system. The first has to do with decisions that we made immediately after the end of World War II and in succeeding years to expand capacity, to build more hospitals, to build more medical schools, to increase medical research—good things on the whole, and we have benefited a great deal from them. But we set off a development that is almost like a delayed time bomb, increasing capacity, increasing the supply of physicians and facilities to such a degree that we now bear the consequences of dramatically rising costs in the 1990s, because that expansion of capacity took place in the context of an unconstrained fee-for-service insurance system, and by its nature, insurance reduces the sensitivity of consumers to price.

But in the case of health insurance, the impact on the providers of services may be even more important. Much of the spending for health care is uncontrollable by an individual consumer. A patient in a hospital generally does not have enough information or confidence to reject recommended treatments in favor of cheaper alternatives. Imagine the patient in a hospital who is faced with a recommendation that a procedure is necessary, saying, well, just a minute now, why don't you check the prices of MRIs around town before you do that? It is inconceivable in the midst of care for patients to exercise much control. Now, consumers do make some key decisions, such as when to seek health care in the first place, but physicians and other health-care providers

generally determine whether diagnostic tests, surgery or follow-up visits are necessary.

In other words, in health care, unlike other industries, the suppliers have a lot of control over the demand for services, especially the services that are most expensive. And that is the single most important characteristic of health care that distinguishes it from other kinds of expenditures in other industries. It is what economists refer to as supplier-induced demand. And only in part is the higher resulting demand the result of the supplier's self-interest in providing more services.

In health care, the suppliers often don't know what works, and they respond to their uncertainty by erring on the side of aggressive intervention. So, when we expanded the supply, when we increased the number of physicians and the specialists, increased the supply of hospitals, we encourage the adoption of the most costly, resource-intensive patterns of medical practice.

This can't be changed overnight. Nobody suggests that it can. But we can begin to set in motion new forces, new incentives, new countervailing pressures in the system to make it fundamentally different, to encourage value-conscious choices, by both consumers and providers about the care that truly serves patients' interest.

In broad terms, I think there are at least five things we need to do. First, to restore and extend health security, we need to change the way insurance works. The economic rewards should not go to the health insurance plan that avoids sick people, but to the health insurance plan that produces the best value for all consumers, whatever their health. And that means eliminating any advantage from skimming off the healthiest people. It means setting new rules, rules like community-rating, open enrollment among health plans, no exclusions for preexisting conditions and risk-adjusted payments to the health plans.

Second, to control costs, we need to clarify the choices and change the incentives facing consumers and providers, and set clear limits on the rate at which the system as a whole can grow. Consumers should be able to choose among alternative plans and to reap the savings from a plan that can deliver to them high-quality care at a lower cost.

Empowering consumers will stimulate competition and hold down costs. But many areas in this country will lack competing plans, and this industry has a long history of anticompetitive practices. So, to ensure that costs are controlled, we need a backstop of a regional limit on the rate of premium increases.

Third, to maintain and improve the quality of care, we need a much stronger emphasis on primary care and prevention, and a systematic effort to improve the knowledge of both patients and physicians about what really works. Consumers need better information about their alternatives, about the quality of care provided by alternative plans and providers; they need to know what kinds of treatment really fit their needs. And the providers also need better evaluative research on the outcomes of treatment. Then we must hold the plans and the providers accountable for their quality of care by publishing measures of consumer satisfaction, of the appropriateness of care, of the outcomes of care. This will spur the plans and the providers to improve their performance.

Fourth, to make the system simpler and more patient- and provider-friendly, we need to standardize coverage, claims and a lot of other aspects of this system to reduce this thicket of bureaucracy that we have built up. We need to apply the same easy-to-use technologies that enable us to complete a credit card transaction anywhere in the country in a few seconds.

Today's payer-clogged health insurance system, which takes months to process claims, is a relic of another age. It increases our costs, it steals our time, it takes doctors and nurses away from their true calling—the care of patients.

Finally, we need to insist on our mutual responsibilities in paying for health care. No one on Earth is blessed forever with good health. Those who do not pay for coverage ultimately shift the burden to somebody else. The burden will be more manageable for everyone if it is spread fairly and controlled.

Mr. Chairman, I appreciate the opportunity to appear, and I would be glad to answer any questions.

[The prepared statement of Mr. Starr starts on p.52 of the Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you. Dr. Wennberg, please proceed.

STATEMENT OF JOHN E. WENNBERG, M.D., DIRECTOR, CENTER FOR EVALUATIVE CLINICAL SCIENCES, DARTMOUTH MEDICAL SCHOOL

DR. WENNBERG. Thank you, Mr. Chairman. I am also very pleased to have the chance to participate in this kickoff hearing. The economic consequences of failing to deal with the undisciplined growth of the health-care sector are enormous. Mr. Staff has outlined those. But the ethical implications are even more important.

At the heart of the crisis is a runaway medical technology and an increasing specialization of the professional work force which favors ever-increasing rates of intervention, and without evidence that more is better or indeed wanted by the patient. The assumption that the health-care crisis results from medical progress and the demand of patients for invasive, high-technology medicine is wrong. The predicament stems from fundamental flaws in the ethical and scientific basis of clinical decisionmaking; the risks and benefits of most medical interventions are poorly understood, particularly from the point of view of the outcomes that matter to patients.

Second, when decisionmaking is delegated to physicians, as has traditionally been done, the prescribing physician's own preferences for treatments and outcomes, rather than the patients, often determine which treatment is used. These flaws then set the stage for an economy dominated by supplier-induced demand. Uncertainty about what works and the dominance of professional preferences ensures the full deployment of available resources, no matter what the quantities.

The crisis in costs emerges from policies that prevailed in the U.S. sector since the 1960s. Finance policies which Mr. Starr has talked about are clearly part of the question. But failure to evaluate the outcomes of care promotes the easy adoption of new technology in the hope that it might work, not with the evidence that it does.

Government programs increase the supply of physicians and promote specialization, creating a work force whose workloads favor invasive treatments. The end result of these policies is a level of investment in acute hospitals and

specialists well in excess of the amount required to produce and deliver services that are known to work or that patients are known to want.

Now, these statements are corroborated by a series of investigations which my group and others around the country have been undertaking in the outcomes of care. Virtually every medical condition could be treated in more than one way. For example, an enlarged prostate, commonly called BPH, or benign prostatic hyperplasia, is a good example. Surgery is one treatment. However, watchful waiting, living with symptoms in order to avoid the risks of more invasive treatment is often a reasonable alternative.

Now, in some parts of the State of Maine, we found in the mid-1980s that the chances that man would undergo a prostate operation by the time he reached 85 was about 15 percent. In neighboring communities, not more than 15 miles away, the probabilities were more than 50 percent. These variations represent the delivery of different perspectives on how to treat this condition, some physicians prescribing more conservative treatment or watchful waiting, others preferring surgical invasion. Outcomes research will, in fact, clarify the underlying theoretical reasons for these differences in practice styles.

We found in our research, for example, that some surgeons believed that early intervention made people live longer under the assumption that the disease would progress to the point of obstructions of the kidney and would cause death. Others didn't believe that. Natural history simply had never been followed. The controversies could not be settled. Outcomes research is the solution for that problem.

We also found, however, that practicing, as most physicians do under the delegated-decision model, physicians' preferences rather than patient preferences for risk were essentially dominating the choice of treatment. In subsequent experiments, we have been able to actually empower patients with information about options, and we found some very interesting results.

We find, for example, that only one out of five severely symptomatic men actually chooses surgery when they have the choice. They would rather live with their symptoms, rather than take the risk of surgery which involves such unpleasant things as incontinence and impotence. Moreover, when patients were informed about options, we noticed dramatic drops in the population-based rates of surgery, indicating that under the old model of practice in this country, there was an excess supply of prescribing physicians for surgery.

When the market is converted to one in which patient demand and information about the risks and benefits are fundamentally available, we find that patients often choose less invasive surgery than they were prescribed under the old model.

Another aspect of our research, which is very important, deals with the problem of excess capacity. Supply exercises an almost subliminal threshold effect on clinical judgment. The effect of a supply of beds on the clinical thresholds for hospitalizing patients provides a very good example.

The supply of hospital resources varies remarkably among geographic areas and the amounts are unrelated to illness rates, or to any explicit theories about how hospital beds should be used, or the numbers that are needed to treat most diseases. There are some famous examples which I have cited in previous testimony. Residents of Boston, for example, have about 4.5 beds per thousand people invested in their health; whereas, residents of New Haven

about 2.9. Virtually all of the excess capacity is invested in the inpatient management of medical problems; and in New Haven and in other market areas with fewer beds, people are treated in less costly settings.

As the number of beds increases, more resources are invested in the care of the chronically ill, as measured by the proportion of people admitted to the hospital and the frequency of re-admissions. Residents living in communities with more hospital beds per capita experience a greater probability that when death occurs, it will occur in a hospital. This threshold effect on the place of death is a constant and increasing function of the per capita bed supply, ranging from about 30 percent of deaths in hospitals in areas of low-bed supply to about 60 percent in areas with high beds per capita.

This greater investment in resources does not appear to result in better outcomes. Mortality rates are not better in areas with greater use and more investment in the chronically ill. If anything, the trend is in the other direction.

Why, indeed, should greater spending bring better results? Hospital capacity is not fashioned on explicit theories about what works in medicine. The optimal number of beds is unknown. One looks in vain in medical texts to learn how many beds are needed to treat a population's burden of illness. Per capita numbers are arbitrary, the product of imperatives of institutions, communities, managed care companies and regulators, not the needs of patients or dictates of medical science.

Similarly, the number of physicians who are trained is governed by equally arbitrary policies, many of which were set in the 1960s when there was a great concern about medical scarcity. The number of physicians trained for each specialty is the product of administrative and political choices, not the numbers required to produce services that are known to work or that patients want. In the case of procedure-oriented patients or specialties, rather, supply is well in excess of practitioners required to produce the treatments that physicians agree are efficacious.

For example, neurosurgeons, when they come into a new medical market, find all brain tumors and all accident cases treated by physicians already there. Their efforts need to be invested either in back surgery, or in carotid endarterectomies, for which there are other medically efficacious and less invasive treatments. And under supplier-induced demand situations, there are no unemployed neurosurgeons.

I show in my written testimony that the numbers of physicians are also well in excess of the numbers required by managed care organizations, such as Kaiser Permanente or Group health Cooperative of Puget Sound.

Now, I think it is fair to say that there is a consistent pattern of evidence that the capacity of the hospital industry and the physicians' specialty work force are now well in excess of that required to provide services that are efficacious and that patients actually want. It is safe for patients and in the public interest to place global restrictions on growth. The Nation can and should deal directly with forces of inflationary growth in the health-care sector with the policies that determine the numbers and distribution of manpower, the size of the hospital industry and the quantities of technology without fear that such actions induce rationing of services that are known to be valuable.

The excess in capacity means that the amount spent on health care can be directly limited and a health-care system achieved which is in equilibrium with other sectors of the national economy without fear that valuable services must

necessarily be rationed. The resources required to meet unmet needs similarly can be obtained by reallocation of excess capacity and not by rationing of effective care.

Whatever shape the Congress may give to the new American health-care economy, I urge that the historic opportunity to promote reform of the scientific and ethical basis of clinical decisionmaking not be missed. The essential base for this reform is a strong, well-funded federal science policy for the evaluative clinical sciences. In an age of increasing technological complexity and increasing sector involvement in health care, it is, in my opinion, essential for public policy to support the needed improvements in the basis of clinical medicine made possible by the evaluative sciences.

It is also essential that federal oversight be dedicated to promoting reform of the doctor-patient relationship.

I would like to close by suggesting four guiding principles. First, the American people should be fully informed about what is known and not known about the outcomes of the treatment options for the conditions they face; second, their preferences should determine the choice of intervention among available options; third, the quality of care should be continually improved; and fourth, it is essential that the outcomes of new as well as conventional treatment theories be continually evaluated and reevaluated. Thank you very much.

[The prepared statement of Dr. Wennberg starts on p.57 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you. Mr. Matthews, please proceed.

STATE OF MERRILL MATTHEWS, DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, NATIONAL CENTER FOR POLICY ANALYSIS

MR. MATTHEWS. Thank you, Mr. Chairman.

There is no mystery as to why health-care spending is out of control. The primary reason is that most of the time when patients enter the medical marketplace they are spending someone else's money rather than their own.

Now, economic studies as well as common sense confirm that we are less likely to be prudent shoppers if we believe someone else is paying the bill. Most economists and health policy analysts recognize this crucial fact. Nevertheless, most health-care reform proposals, including the President's, attempt to increase the role of third-party payers rather than diminish it. Because reformers know that increasing third-party payment will only increase spending, they want to hire a manager or government employee to look over the shoulders of the physicians and the patient to ensure that no one is consuming too much health care. Such proposals, which have been tried under Medicare, go in precisely the wrong direction and will never reduce health-care spending without significant rationing, which the American people will never stand for.

Now, it is true that most polls show that most people fear that they will not be able to pay their medical bills from their own resources. But the reality is that most of us pay for only a small portion of the medical care we receive. For the health-care system, as a whole, every time we consume $1 in services, we pay only 21 cents out-of-pocket. Moreover, the explosion in health-care spending over the past three decades parallels the rapid expansion of third-party payment for medical bills. The patient's share of the bill has declined from 48 percent in 1960 to 21 percent today.

If we bought food the same way we buy health care, we would walk into a grocery store, we would have nutritionist come up and take us along the aisles; there would be no prices on any of the food that we would be picking up; we would go by and pick up everything that we wanted, from sirloin steak to the most expensive gourmet items; we would go the checkout stand and hand them our food insurance card—we might pay 5 percent of the bill— and then we would leave. If that happened in food, the prices of food would be skyrocketing as well.

Incidentally, when people talk about health care being a fundamental right, something too important for us to leave to the private market, let me point out that there is something more primary to our needs than health care, and that is food. And by and large, the food industry is totally private. We go to for-profit grocery stores where people pay low prices, they get very good service and there is a great deal of information being put forth out there by the people who are selling the product. And, incidentally, you don't have the right to go to the grocery store if you are hungry and demand that they give you good, as you do at the hospital.

Now, how did we get into this situation? Largely because of government policies. Under current law, every dollar of health insurance premium paid by an employer escapes income tax, it escapes social security tax, and it escapes state and local taxes. The government is effectively paying up to half the premium, which is a generous subsidy that encourages employees to overinsure. At the same time, the Federal Government discourages individual self-insurance by taxing income that individuals try to save in order to pay for future medical expenses. As a result, a great deal of the waste in our health-care system is caused not by people who have too little health insurance, but by people who have too much health insurance; and one way in which people overinsure is by pressing their employer for low deductibles, or in some cases, complete, first-dollar coverage.

Low deductible health insurance is usually wasteful for three reasons. First, low deductible insurance encourages people to consume services they do not really need. That ultimately causes cost and premiums to rise for all policyholders. Second, low deductible insurance discourages people from seeking low prices for the services they do consume. Third, using insurance to pay for small medical bills tends towards wasteful administrative expenses. For example, a $25 physician's fee can easily become $50 in total costs after an insurer monitors and processes the claim, thus doubling the cost of health care. This overuse is leading to a number of changes in the way health care is delivered.

Because health insurance is the primary method of payment for the medical care Americans consume, in a very real sense, it is the insurer rather than the patient who is the customer of medical providers. For example, when Medicare patients interact with the health-care system, what procedures are performed and whether a procedure is performed increasingly is determined more by Medicare's reimbursement rules than by the patient's preferences or the physician's experience and judgment.

Although this phenomenon is more evident in government health-care programs—Medicare and Medicaid—private insurers in large companies are increasingly copying the methods of government. As a result, we are not evolving into a two-tiered system of medical care, but into a multitiered system in which the quality of care a patient receives is increasingly determined by the third-party payer.

The way medical care is now being delivered, Medicare patients can receive one type of care, Medicaid patients could receive another, and Blue Cross patients receive still another.

But while government policy has encouraged many employees to overinsure, it also adds to the number of uninsured in three ways. First, federal tax policy encourages an employer-based system in a very mobile labor market. When people leave a job, they eventually lose their health insurance coverage. Second, government tax policy encourages people to remain uninsured while they are between jobs in which they would have employer-provided coverage. Currently, government spends more than $90 billion a year in tax subsidies for health insurance, mainly by allowing employer-provided health insurance to be excluded from the taxable income of employees. As a result, some employees receive tax subsidies of 50 cents for every dollar of health insurance that they purchase. Yet, those who purchase their own health insurance get no help from government and often pay twice as much after taxes for the same coverage. Those discriminated against include the self-employed, the unemployed, and employees of small businesses that do not provide health insurance. And finally, state regulations are increasing the cost of private-health insurance and pricing millions of people out of the market. For example, state-mandated health insurance benefits laws tell insurers that in order to sell health insurance in a state, they must cover diseases ranging from mental illness to alcoholism and drug abuses, services ranging from acupuncture to invitro fertilization, providers ranging from chiropractors to naturopths. By one estimate, one out of every four insured people has been priced out of the market by state-mandated benefits laws.

In addition to mandates, private insurance is burdened by premium taxes, risk pool assessments and other regulations. Ironically, most large corporations are exempt from these regulations because they self-insure. As a result, the full weight of these regulations falls on the most defenseless part of the market, the self-employed, the unemployed, and employees of small businesses.

Gentlemen, there are a number of plans out there to promote health-care reform. Any plan that expands the impact of low deductible health insurance—and that is the key, low deductible or first-dollar coverage health insurance—under any plan that does that, spending will not decline, it will explode.

Now, there are only two ways to control that health-care spending. You can either control it from the top down or you can control it from the bottom up. Because the Clinton plan envisions covering so many people for so many things, it will need drastic, strong-armed techniques to control spending.

There is, I believe, a better way. Simply return the money to the patient through Medical Savings Accounts so that they will benefit from prudent health-care spending.

The real issue that is going on here is who is going to be in control of the health-care system in America? It will either be bureaucrats and managers or patients in consultation with their physicians. Dr. Wennberg, in his writings, has made a very strong case that educated patients tend to choose less expensive, lower technology types of procedures. We believe that 250 million patient-consumers, acting in their own self-interest, will do the best job out there of controlling health-care spending.

Thank you Mr. Chairman.

[The prepared statement of Mr. Matthews starts on p.68 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you. Mr. Feezor, please proceed.

STATEMENT OF ALLEN D. FEEZOR, CHIEF DEPUTY COMMISSIONER OF INSURANCE, NORTH CAROLINA

MR. FEEZOR. Thank you, Mr. Chairman. I too am honored to appear before this panel, and also to appear on such an illustrious panel. I compliment you and your staff.

Mr. Chairman, I am Allen Feezor. For nine years, I have served as North Carolina's Chief Deputy Commissioner of Insurance under Commissioner Jim Long, who is an elected official. I have been in health policy for 19 years. In the last two-and-a-half years, I have worked quite a bit with the National Association of Insurance Commissioners in the efforts of looking at both small group reform and rating reform proposals.

While I was asked to appear here and draw on those experiences, I should quickly say that my opinions are strictly my own and not that of the North Carolina Department of Insurance or the National Association of Insurance Commissioners.

Mr. Chairman, in discussions with staff earlier today, I have decided to depart rather substantially from my prepared remarks, and would ask your permission that I might revise and provide some addenda to those comments later.

Mr. Chairman, one of the things I was asked to look at was the evolution of risk segmentation and rating in the insurance industry. In providing a quick historical perspective, I guess I would highlight six or seven events. I think first—and I think Mr. Starr mentioned this—is the establishment of the early hospital and medical service plans which literally did ask everybody in the communities that plans served, to contribute equally and then to share equally in those services when needed. As soon as these plans showed that prepaid health care could in fact be made a going matter, we had the entrance of predominantly commercial insurers who brought with them not only their ability to profile risk, largely on age, sex, geographic locations, but also on their ability to differentiate in subtle forms in terms of benefit design.

But if I had to pick a couple of key events, I would have to say that government has had its share. As Professor Starr has indicated, I think the advent of Medicare and Medicaid certainly segmented the risks that we had in the 1960s, although I think it is fair to say that, for the most part, the remaining risk in the insurance pools benefited by this offloading of retiree costs. Another event that I would point to, which perhaps is not often thought of, is the federal HMO Act. I say this notwithstanding the fact that the HMO Act at the time it was passed required community rating and now requires adjusted community rating. Nevertheless, it further segmented the risk pooling and in fact, interestingly enough, did so within some of the very employer groups that had sought to segment their own experience from the traditional market. Now, many large employers feel that they are being adversely selected against by some of the HMO selection process.

Without a doubt, though, I think probably the largest segmenting event, the most destructive force, in terms of the pooling of risks in the health

payment field, was the enactment of ERISA. While experience rating had been very commonplace, ERISA certainly removed any doubts as to employers' and insurers' ability to exit from existing insurance pool and to establish their own risk and rating practices, and also—as both of the gentlemen to either side of me have indicated—to avoid such things as financial reserving requirements, consumer protection, taxes and, indeed, mandated benefits.

It should be pointed out that approximately 50 percent of the market now—and it may vary from 40 to 60 percent, depending upon the state or the area—are now in self-funded arrangements.

Two other factors, in the history of this evolution—and I think it was Professor Starr that indicated this—I think the hyperinflation in the entire economy, but certainly in the health care industry, that we had in the late 1970s and early 1980s accelerated the trend toward self-funding.

Second, in the mid-1980s, we were lulled into thinking that we had done something with health-care costs. After Medicare moved to a DRG, there was a slight abatement in health-care inflation. When it reescalated, I don't think there is any doubt that it caught a lot of the insurance industry sleeping. The responses happened to come at this particular time, right after, probably the worst casualty insurance crisis in the country. During this time, insurers basically exited the market, began to do mid-term cancellations, nonrenewals. In response to the reescalation of health-care costs in the late 1980s, we found many of our health insurers unfortunately mimicking some of the same characteristics of the casualty insurance industry.

I think the conclusion was that it dramatized without any doubt that competition, certainly in the smaller group market, had evolved to be competition based on risk selection, not cost containment, despite what the industry might have said. And, in fact, I would go further and say that insurers sought to avoid rather than spread risk.

Mr. Chairman, to fully understand the power of risk selection, favorable risk selection, I would suggest that this Committee try to keep in mind two principles or two premises.

First is what I call the lowest common denominator factor, which is very present in a competitive markets. That is, if one company uses even a perhaps less-than-socially desirable factor or means to siphon off preferred risks, invariably other carriers will have to respond and gravitate towards similar conduct. Not to do so subjects that insurer not only to adverse risk selection, but in fact to potential financial ruin, at least in that particular product line.

The second premise or principle that I think is important are the odds that are at stake in risk selection. And that is, you have heard the various claims, but basically 5 percent of our population accounts for about 50 percent of the claims cost. Those ten-to-one odds are very, very important. Take two insurers looking at the same market: One insurer may invest a great deal of time and energy in developing data systems and profiling providers, and save 10 to 15 percent against what the standard market is currently paying. Insurer number two, by employing some very sophisticated risk avoidance or risk selection techniques, may just be able to identify with some degree of regularity and, more importantly, to avoid that one in twenty persons who in fact contribute so much to the claims cost—50 percent.

Which one has in fact come out ahead, at least in the short run?

In short, Mr. Chairman, I believe that the vast majority of the insurance industry are addicted to risk avoidance and the powerful odds behind them. Like addicts, they will find some way to pursue this, despite vigilant regulators or alliance or HIPC managers of the first order, and despite rather prescriptive regulation or legislation.

In my prepared remarks, I highlighted some of the most widespread or common risk factors or rating techniques. I would quickly say that they are but the tip of the iceberg and the most obvious ones. The discreteness and the sophistication of this field is unlimited, is expanding every day, and is compounded by our society's ability to process massive ranges of data and to amass data about individuals and risks, as well as providers. And I think it is further compounded, Mr. Chairman, by our ability to identify risk through biological and other genetic testing and advances in medical science.

Some 40 states have enacted some variation of the National Association of Insurance Commission's rating reforms. These are aimed, I would quickly add, only at the most pernicious rating practices. They did not eliminate many of these practices. In fact, they simply prescribed the borders within which rating practices can continue.

Clearly, I think most would agree that we have to do more with regards to health-care reform. I would quickly note this more parenthetically: In trying to implement the rating reforms in states, it has become very apparent that many within the industry, and in the actuarial community as well, believe that if they can simply identify a factor that is statistically valid which will produce a better bottom line that they should be allowed to pursue that, regardless of its impact on society or the overall risk pool, and even though it may be fundamentally in conflict with the premise behind many of the rating reform models adopted.

And I think therein is a major problem. It is an attitudinal change that will take some time.

As I discussed in my statement, there are many who would point to community rating as a solution. While there are some benefits in that, these are, as I also noted in my prepared remarks, not without complications in terms of social equity, economic equity. And then there is a problem with the transition of how we get from where we are today to community rating.

Two final points, Mr. Chairman: Many states like California, Florida, and my own State of North Carolina, are setting up purchaser alliances. Many are broadening risk pools, and in if so, I think that would be a salutary effect. And yet, I feel certain that alliance managers or HIPC managers—whatever you would like to call them—will continue to face the tremendous pressures of risk segmentation, given how strong those incentives are and how firmly entrenched those tendencies are in the current private-insurance industry.

Furthermore, I think these problems will be proportionate to the amount of rate variation. In my opinion, participating carriers will be impacted by the amount of variation in plan benefits, or the ability of those carriers to supplement the basic coverages provided. And I think the problems will be further compounded by the number of carriers. And it will be problematic to assure that there is not counterproductive risk selection if HIPCs or alliances are placed within the existing voluntary market.

If, in fact, alliances or HIPCs are not to be exclusive, it is absolutely essential that the voluntary market abide by the same rules that the HIPC/Alliance

has to abide by. And I think it is equally important that, as we watch these develop in those states which are stepping out on this issue, that we look at the relative impact of those alliances on the remaining markets and vice versa.

Finally, Mr. Chairman, I think that while the purchasing alliances hold some promise or some potential of cost reduction, or at least retarding the growth in cost, it remains to be seen whether we will be comfortable giving them the sufficient clout and/or latitude to exact the kinds of fundamental changes and the savings that some would hope that they would have on the health-care industry.

Thank you very much.

[The prepared statement of Mr. Feezor starts on p.75 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you very much. Let me start by observing that I have seen some critics of reform that suggest that we can bring costs under control without having universal coverage.

Let me just ask all of you, what would your response be to that assertion?

MR. STARR. I don't think so.

REPRESENTATIVE OBEY. Why not?

MR. STARR. I think we have been fooling ourselves that excluding people from coverage is helping us to control costs. In all the years that we have done without universal coverage, we have had the highest growth in health-care costs on Earth.

Sure, if we added coverage to the existing system without any reform, that would raise costs. But the move to universal coverage is the opportunity to change the way the system works, to change the incentives to empower consumers, to create the countervailing pressures to control costs.

If we tried to impose a system of rigorous cost containment without universal coverage, there would be great pressures within the health-care industry to close in effect the doors on the poor, because they would no longer be able to pass along the costs of uncompensated care. And I think that would bring about an enormous political reaction—people would find it intolerable.

We cannot achieve the social consensus, we cannot build the necessary political coalitions to get cost containment unless we bring everybody in.

REPRESENTATIVE OBEY. Does anybody disagree with that?

MR. MATTHEWS. I would disagree with that.

REPRESENTATIVE OBEY. I thought you would.

MR. MATTHEWS. In effect, quite honestly, we have a system of universal coverage now. Across the country you have public hospitals established that are there to cover people who do not have money for health care. Right now, in my city, Dallas, Parkland Memorial Hospital covers that. They will see at their outpatient clinic approximately 800,000 people this year; 62 percent of that is unfunded.

It is not the best system; it is not the most efficient system. People have to wait in line when they go there. But if you need health care and if you need it immediately, you can go right into the emergency room, you can get health care. If you don't have the money to pay for it, the county covers it. They can get health care. So you have a sense in which we do have a universal system now.

You can also control costs simply by changing the nature of the way people understand health insurance. Right now, the mentality is that if I don't have first-dollar coverage, I am not covered; I don't have complete protection. We have to change the nature of the debate so that people understand that if they have high deductible insurance, they are covered for catastrophic losses, and we have to put the emphasis back on individuals making value-conscious decisions.

Professor Starr talked earlier about value-conscious patients out there, and I appreciate the term. I am not sure how it would work under his system, but what we are trying to do is to put money, with Medical Savings Accounts, back to the individual patients so that they have to make a decision as to whether or not they want to spend the money on health care or not. If they don't spend the money, they benefit by keeping the money, but they have a pool of money set aside in order to do it.

The only way you are going to control health-care spending is if people have a sense of trying to get value for their dollar. That is not the case in the health-care industry right now.

REPRESENTATIVE OBEY. Are you comfortable ethically with the idea that we ought to continue to have millions of people who are outside of the regular insurance system confined to public hospitals if they happen to live in an urban area where there is one?

I mean, do you really think that your response is satisfactory from an ethical standpoint? I don't mean personally, I mean at a societal level.

MR. MATTHEWS. Since I am a medical ethicist and the ethicist for a hospital and for an institutional review board, let me respond as an ethicist. The ideal would be to have as many people as possible covered under some type of high deductible insurance to cover the major expenses.

Apart from going to a straight type of Canadian system, you will never have everyone covered, because in any kind of system in which you are administering it through a health insurance company, a HIPC or whatever, they have to be able to have a place where the person is living, they have to have some way to administer the system, and have contact and communication with the individual.

We have a small percentage of our population who are simply going to be transient, indigent. You are not going to be able to administer anything other than a Canadian-style system to them. But the ideal is to get virtually everybody else covered under a catastrophic policy, with some money set aside in a tax-free fund so that they can go and purchase health care with that money.

REPRESENTATIVE OBEY. Let me ask you a specific question. My younger sister died of cancer about five years ago. Let me explain her situation. She worked for a company that wound up running into tough times, laid off about two-thirds of their work force. So both she and her husband who worked at that same company were laid off.

The last thing she said to me was that she was happy that she was going to die before their insurance ran out, because they were both unemployed, and the following week they were both out of insurance benefits from that company.

Now, how in the hell is a personal IRA going to help somebody in that situation?

MR. MATTHEWS. The medical IRA is an attempt to redirect the way we think about health care. Along with that, you want to have some health-care reform proposals in there, one of them making health insurance personal and portable so that the individual owns the policy and they can carry it with them, and the insurer cannot come in and automatically begin raising the premiums or canceling the——

REPRESENTATIVE OBEY. Her problem wasn't canceling, or that the premiums were being raised. Her problem was that since she worked for a company and that company ran into hard times and they were unemployed, they simply lost coverage, period.

MR. MATTHEWS. The policy was not——

REPRESENTATIVE OBEY. They were not a welfare case, they were two people working their butts off, trying to make a living.

MR. MATTHEWS. I understand. That is why I say personal and portable. If it was portable so that it belonged to them like their auto insurance. They wouldn't be concerned about their auto insurance, because they own their auto insurance policy. You aren't concerned about homeowners insurance when you leave a job, because you own your homeowners policy. So if they had owned their health insurance policy, if it was portable, they would have continued to have the coverage.

REPRESENTATIVE OBEY. How? How could they pay for it?

MR. MATTHEWS. Well, you have the money set aside in the medical savings accounts for that.

REPRESENTATIVE OBEY. If they could afford to take out the IRA in the first place?

MR. MATTHEWS. That is right.

REPRESENTATIVE OBEY. What if they couldn't?

MR. MATTHEWS. Well, what we are supporting, Congressman, in the medical IRA, is using the same money that now goes to buy low deductible health insurance and take that money and let the individual buy the high deductible policy for less.

REPRESENTATIVE OBEY. So you like the policy of trying to reinforce individual insurance?

MR. MATTHEWS. Yes. I am not sure I am comfortable with reinforce, but return to might be better.

REPRESENTATIVE OBEY. Frankly, that baffles me, because most of the evidence that I have seen indicates that individual insurance is by far the most expensive to provide.

MR. MATTHEWS. It can be more expensive, and it can also come through an employer. This happens across the states in many cases. In fact, Texas just adopted this in a health-care reform proposal. They created a conversion privilege in there.

You also have COBRA—Consolidated Omnibus Act—which permits people to carry their health insurance with them after they leave a job. We would like to make that more permanent.

REPRESENTATIVE OBEY. I guess I would simply say that in the case of my sister, and I think for an awful lot of Americans around this country, their problem isn't—and her problem wasn't—that somebody is jacking up the rates or that they haven't been able to make an intelligent, informed choice about

something, although certainly that is a problem; their problem was very simple. Health care was has not been seen as a right in this country, and so people who run into tough times get left in the gutter, and left to fend for themselves. And it just seems to me that ethically that isn't an acceptable response.

Mr. Starr, would you have any comments on the question that I just raised?

MR. STARR. Yes, sir, I would. I sympathize with Mr. Matthews' problem, because he is trying to do something, which an advocate of the free market must appreciate as extremely difficult, and that is that his remedy doesn't sell, it just doesn't sell. And so he has a very big problem.

People have tried to market these catastrophic policies that he is talking about, the bare bones insurance policies, and there isn't any market for them. People won't buy them. It is not what the public wants. He wants to shift back on to the individual consumer more of the cost, and people don't want, and in fact it is not a good solution.

As you mentioned, Mr. Chairman, the administrative costs of the individual insurance system that he wants are the highest that we could experience. He would encourage exactly the kind of market that Mr. Feezor is concerned about, that insurance companies have an interest in investing more resources in screening out high-risk people. Moreover, there is no effective cost control in that approach once you get past the deductible.

Once you are in the hospital and past the deductible, there is no control of cost. In fact, that kind of insurance emphasizes the most high-cost services at the expense of primary and preventive care, for which it doesn't provide any coverage.

So I don't think that is a solution to our problems; I don't think that is the way the public wants to go. I think it is not worth our spending a lot of time on. But I am sure that there are members of the Minority who disagree with that.

MR. MATTHEWS. Just one response to that, though. It is true that high deductible insurance policies have not sold well right now and that is because, by and large, people have to cover that deductible with after-tax dollars rather than pre-tax dollars.

If you give them medical savings accounts instead of giving the money to the health insurance companies, they put it in the medical savings accounts, it is pre-tax dollars and then you would have the money set aside for that.

REPRESENTATIVE OBEY. If you two want to respond briefly. My 10 minutes are up, but I will extend Mr. Cox's time as well by the same amount.

Dr. Wennberg, did you want to say something?

DR. WENNBERG. I just wanted to draw attention to the problem of how we frame this whole debate. When you look at the question of the uninsured and you ask where are the resources going to come from for entitlements, at one level, it is an argument about how you distribute insurance or how you distribute value, purchasing power.

On the other hand, if you look at the problem that I have been trying to raise of the excess capacity that is in the system, you see immediately that the problem is essentially redistributing the rights to what is there already. And the problem that we see with shrinking numbers of insured people is that in

fact they are becoming more and more medicalized, they are getting more and more treatments because the capacity is already in place.

Example: I bring up again this problem of Boston and New Haven, where we see expenditure rates in Boston going to 18 percent of the GNP for local residents, compared to New Haven where we are talking about 12 percent. You could increase by 50 percent the population of Boston before their expenditures would approximate those of New Haven, and no one would know the difference, because it is all in this subtle threshold effect of the aggregate supply as it exercises its power over the prescribing physician when he tries to solve medical problems.

So remember that, because we see no advantage in this excess investment. The problem is to empower patients, the full population, to have the access to what is already there, and then to worry about the quality problem.

MR. FEEZOR. I hesitate to jump in the middle, but I have a feeling I am going to be in the middle, given my position at the table here. Two observations: I think the difficulty of selling either the bare bones or, for that matter, a purely catastrophic policy is well-documented. The American consumer, for better or for worse, wants (a) value, and (b), bases that judgment on what they see as the coverages that are out there now, and that tends to be fairly low deductible, fairly comprehensive coverage. So it is going to be a hard sell.

Second, the other key is, if it is left to the discretion of an individual, it becomes a matter of "what am I going to do with that additional discretionary dollar, that marginal dollar?" And I think one of the problems, as dramatized by the fact that the highest percentage of people who are uninsured tend to be those under 25, who are absolutely the best risk, should be the lowest cost. Yet, they have the least disposable income, and hence they are least inclined—as there are so many other uses in starting out, such as purchasing a car or whatever.

I think you put your finger on exactly why I think the answer to your question of how can we hold down health-care costs without providing comprehensive coverage. I think we can—I will agree with that—but I think it will take such an intense regulatory system, both of providers and of insurers, that if we think we have a problem with the administrative costs now, "we ain't seen nothing yet."

REPRESENTATIVE OBEY. Thank you.

Mr. Cox?

REPRESENTATIVE COX. Thank you, Mr. Chairman.

We have covered a great deal of ground and I am not quite sure where to begin, but I think I might begin with Dr. Wennberg, and ask you about a comment that you made in your testimony where you were describing public policies that have supported the open-ended financing of care as responsible for an increase in health-care costs, and specifically you have said the Federal Government, through its Medicare program, has contributed substantially. We talked just briefly about that on the panel here, and I wonder if you could elaborate.

DR. WENNBERG. Certainly. The open-ended financing of health care simply allows all other inflationary trends to work their way through. I would argue that if we had approached our manpower policy differently, if we had not increased the supply of physicians, if we had not urged their specialization,

then we would not have seen the trends that we now see, even though we have this open-ended financing.

So it is the financial structure, coupled with the incentives to increase the intensity of investments in high-technology medicine that lead to this continuous undisciplined growth. And when I use the word "undisciplined," I mean in the sense of the end value of that for patients in terms of whether they prefer that form of treatment; and second, whether it objectively, in fact, enhances their outcome.

REPRESENTATIVE COX. This open-ended financing component is something that you, Mr. Matthews, described as pressure to increase costs, and I wonder if I could ask you and Mr. Feezor to react to this notion: As part of our reform, what if the Federal Government mandates that no health plan may charge some patients more than others because of any factor related to risk?

Mr. Feezor, do you want to start?

MR. FEEZOR. In my remarks, I think I alluded to problems of how to get from this side of the canyon to the other. In fact, the small group reforms, let me draw from that a second, and I think it will be a helpful illustration.

We found rating variances as much as 600 percent for similarly situated risks; that is, to be charged six times what another one would. The rating reforms as proposed by the NAIC model, and most states are adopting are trying to bring that down to about 200 percent, exclusive of demographics-age, sex, which can again expand that, and geography.

In looking at some runs of the market and what that impact would be in North Carolina, we found that for every one person whose cost you reduced—and it could be substantial reductions—you had about four losers, people who were sitting here enjoying relatively good rates now, whose rates would be forced up by this comparison toward a community rate.

And I think that is, quite bluntly speaking, a very tough economic and political issue that will have to be dealt with. So most of those reforms called for, even when you bring down the range to 200 percent, and you are proposing that it be at a mean here, that we allowed three to five years to compress those rates. And even then, that has compounded the cost problem for some.

I think it is an appropriate goal to have something akin to a community rating. I think what is absolutely critical, abscent that, to at least prescribe those factors that are socially acceptable, that can be used in determining those rates. It may very well be that for young people, you won't lower rates, but that is a judgment that Congress would have to make.

REPRESENTATIVE COX. Do I understand you correctly, at least empirically, that as you tend toward horizontal equity, you do so at a level that is higher for a disproportionate number of people than they were paying before?

MR. FEEZOR. Yes, sir. I think what has to be done is that you have to find sort of a "rate shock absorber," if you will, that will be some subsidy, or offset, that at least eases the impact of the compression of the rating.

REPRESENTATIVE COX. Mr. Matthews, I want you to react to this same notion. I didn't make this up; I read this in the President's national health-care plan. To quote

> No health plan may charge some patients more than others because of factors related to risk.

Will that work?

MR. MATTHEWS. No, it won't. And the reason it won't is because you have to have prices based upon what something costs. Now, as Mr. Feezor is saying, when you put in community rating, you raise the cost for the young healthy people, and you reduce the cost for older or sicker people.

Now, since we have been talking about analogies here just a little bit, right after New York produced their community rating bill, I had a young lady call me; she had seen an editorial that the National Center for Policy Analysis had run in the *New York Times*. She was upset because she was a college student just getting out, and her policy only cost her $400 a year, according to what she was telling me, and she had just gotten a letter, and because of the community rating, it was going to go up to $1,200.

She was young, in her 20s, healthy, no health-care problems. She just did not feel like it was worth the cost to raise it up there. The community rating does that. It has to balance it out so that the majority of people who are uninsured, or who would have cheap prices, that is the young, healthy people, end up being charged more, and they voluntarily decide to step out of the market.

Furthermore, what the Clinton administration wants to do is not only have the community rating so that everybody pays the same price, it wants to have guaranteed issue; that is, no one is restricted from getting health insurance whenever they want it.

Now, the question we raise time and again is: If you get it at the same price and you can't be refused health insurance, why would healthy people buy health insurance?

REPRESENTATIVE COX. Well, of course, one reason might be that in this plan, it is mandated that everybody do so.

MR. MATTHEWS. That is one way to approach it. And that is the only way they can solve the problem.

REPRESENTATIVE COX. Has everybody on the panel read this? It is rather thick. It was leaked out. Has anyone had a chance to read it?

MR. STARR. Yes, I certainly have. I would like a chance to——

REPRESENTATIVE COX. Are you sure you have read this? Did you read this?

MR. STARR. Yes, I certainly have.

REPRESENTATIVE COX. Okay. In that case, let me ask you this question.

MR. STARR. Can I just respond to the previous one, though, first?

REPRESENTATIVE COX. What was that?

MR. STARR. The previous question about community rating?

REPRESENTATIVE COX. What was the question?

MR. STARR. About whether its effects would be to increase costs for many consumers.

REPRESENTATIVE COX. Mr. Feezor's point.

MR. STARR. I think we need to consider two things. First of all, in the current market, there is a very, very significant cost shift from the uninsured that people who now buy insurance are paying. That is, the rates at hospitals are higher because the hospitals do not receive payment for uninsured patients, and those higher rates result in higher insurance premiums for the employers and employees who now buy insurance.

When you have a system of universal insurance, you take out this cost shift that now falls on those who currently pay for health care.

REPRESENTATIVE COX. Mr. Feezor, do you want to address that point?

MR. STARR. And when you put that out, rates go down.

REPRESENTATIVE COX. I understand your point, I just want to keep some control of the questioning here.

Mr. Feezor?

MR. FEEZOR. I don't think I would disagree with what he is asserting, that you should achieve some savings with universal coverage. But I took your question as being strictly about rating on a community rating basis, and that did not necessarily imply in a universal coverage setting.

REPRESENTATIVE COX. That was, I think, the precise distinction.

MR. STARR. In other words, in a universal coverage setting, those who now pay for health care pay less. You have many, many more winners than in the current market than if you try to do community rating alone. There are also some other effects. In a universal coverage setting, you spread the cost of families across employers. So employers who are now paying for the entire cost of the family will pay less.

In fact, I think that when we see the full data on how much employers pay, you will see that those employers who now pay for health insurance will pay significantly less under reform, because of taking out the cost shift and because of the spreading of the costs of families over employers.

REPRESENTATIVE COX. Mr. Starr, I want to apologize for my expression of disbelief when I asked you twice whether you had read this. The only reason is that it was published September 13, 1993, which is today, and it is over 240 pages long. And it is 11:30 in the morning, and you have been here for a few hours.

REPRESENTATIVE OBEY. Well, I read it.

REPRESENTATIVE COX. What I read was what was leaked in the newspapers, which were excerpts of it. It came out first in the *New York Times* on Saturday, and unfortunately I was flying out to California, and I was on an airplane for five hours and got to spend a good bit of time going through the overview.

But one of our great frustrations in Congress, as you can imagine, is this rather substantial report that is out and about has yet to be provided to Congress by the Clinton Administration. The Bureau of National Affairs was good enough to print it for us today, and I will be able to spend some more time this week in trying to get through the 240 pages and understanding them.

I will say, from my reading of this, it contains a very descriptive and detailed national health-care insurance plan, or contract. It looks for all the world like a regular insurance contract. It has the tables, here is what coverage is provided and what coverage isn't provided, and what it amounts to basically is the Federal Government displacing private insurance with its own mandated one-pan-for-all-of-America, or to put it a little differently, all peasants shall join the collective.

If you change the word alliance to collective, that is what we are doing. Everybody in America, like it or not, is going to be collectivized. We are going to do to health care in America what Stalin did to agriculture in the Soviet Union. And the result of this is that you will get to pick your plan from your collective and nowhere else.

The collectives don't compete. There is no competition among collectives. They get a monopoly. Earlier it was mentioned that these private plans are very expensive. Do you know what the most expensive employer provider in America is? The Federal Government's.

Fortune Magazine did a story about this. The plan that Congressman Obey and I have is the most expensive employer-provided plan in America. We get lower benefits for higher costs.

REPRESENTATIVE OBEY. You don't know what plan I have.

REPRESENTATIVE COX. Well, that is true. If you don't get yours through the Federal Government, you might be doing better. But my concern is this. We are putting in a monopoly position the high-cost provider—the Federal Government. Our objective is to reduce costs, reduce paperwork and so on.

Dr. Wennberg mentioned that Medicare, by providing open-ended financing along with other factors, has contributed to the health-care cost explosion. Aren't we, as Mr. Matthews says, going to see more rather than less of this by universal access, which is essentially what this health-care card is going to provide.

You get for no deductible, or a $10 deductible, all of the services that are contained in here at somebody else's cost. Or to again translate the language, if you change employer to bourgeois, employee to peasants, and health-care alliance to collective, you find that the bourgeois must pay 80 percent of the cost of the peasant's health care. Why isn't that so?

MR. STARR. Because you have completely misrepresented what you have read, Congressman Cox. The approach taken in that report, and it is only preliminary—it is not the President's final program—the approach that I described in my testimony enables consumers to choose among alternative competing plans. In fact, people will have more choices than they have today. The majority of people working in a firm who do get, who are lucky enough to get insurance, only——

REPRESENTATIVE COX. Let me just say, that isn't true. The fact is that there needs to be only one fee-for-service plan in a collective, and I have to join the collective, and therefore I will get only one fee-for-service plan when now I can buy from a number of insurance providers, and get less choice.

MR. STARR. That is not true.

REPRESENTATIVE COX. What is not true about it?

MR. STARR. You are confusing the universal guaranteed benefit package and whether or not there is one organization that provides it. In fact, under this approach, there would be many competing plans providing that benefit package. The idea——

REPRESENTATIVE COX. Let me quote from the Clinton plan, as written in the *New York Times,* September 11, 1993:

> Each alliance—what I call a collective—includes among its health-care plan offerings at least one plan organized around a fee-for-service system.

So there is no guarantee that I will get more than one choice from my collective for fee-for-service.

And furthermore, to read further on, it turns out that they are regulating rather strictly what that particular fee-for-service plan can do. And, as a

result, there will be no competition and not necessarily what I want, and I won't get to go anywhere else, because it is mandated that I join the collective.

Mr. Matthews, I only have a minute left, but I want to ask you one final point. You are holding up the Republican end on this table. As you know, you are the only one the Republicans have on the panel, and Mr. Starr, for his part, I think is a very able person for you to keep up with.

But let me just ask you this final question: We are establishing, according to this document that I am still reading, a national health board that is going to establish requirements for state plans. It is going to interpret and basically regulate the nationally guaranteed benefit package for all Americans. Is that a good idea? Is this going to reduce costs?

MR. MATTHEWS. Well, the question I would ask, if there are so many winners under national health insurance, why do all these winners come to America to get health care so often? What you have is a system here in which people from these other systems make the trip down to America.

One of the fastest growing businesses in Canada is a group of physicians who went in with a couple of Canadian physicians, and if your waiting in line in Canada is more than four months, they will buy you the round-trip airfare and fly you to America so that you can get treatment and not have to wait for four months. That is one of the fastest growing businesses in Canada, according to National Public Radio.

What we are going to create? We are not going to create a single Canadian system under this; we are going to have 50 little Canadian systems, because you will have health-care purchasing alliances in each state, which will basically be a monopoly with control over what is going on.

Most of the large companies will drop out of the system because large companies now pay in the neighborhood of 11 percent, 12 percent of their payroll towards health insurance. The Clinton plan is guaranteeing that they won't have to pay more than 7.5 percent under his plan, and if you are given that option, most of these large employers who might be able to insure because they have 5,000 or more will just dump them into the plan, you will basically have a single plan.

Now, if this is true, if the government could hold down costs by working through this central system, you would expect defense costs to be the cheapest in the world, and you would expect education to be some of the cheapest in the world. But, in fact, virtually every place where the government comes in and takes control, with the promise that they are going to improve quality, as they said they would in education and lower costs, just the reverse happens, costs rise and quality decreases.

REPRESENTATIVE OBEY. The gentleman's time has expired. Let me say that I am very happy that this exchange has taken place, because I think it illustrates what the President is up against. I mean this hearing was not called to debate the President's package; it was called to discuss the existing health-care system. But it is very apparent from seeing the reaction to the leaks that have occurred on the President's plan that there are some people whose purpose is to attack it before they have even finished reading it, that they will grab every opportunity to do so, even to the point of comparing it to Stalin.

Now, I think I will let those assertions and their essential silliness stand on their own merits and people can judge them accordingly, and I won't even respond.

REPRESENTATIVE COX. I think you just did.

REPRESENTATIVE OBEY. No, no. If I really responded, we would be here a long time and I don't think it is worth it. To deal with the assertion that somehow it is the greediness of the American consumer on health care which is driving these costs—which I find a quaint assertion—but it is being made all over this town, I think we ought to compare some realities of the existing system.

If you take a look at this chart, you see where the United States ranks in terms of spending, in comparison to other countries. Here we are at more than 13 percent of our gross domestic product in comparison to Greece at 5.2; Japan at 6.8; Germany, 8.5; even the much-maligned Canadian system at 10 percent.

Now, if that is true because we have such an overutilization of health care driven by consumer demand in this country, then I am curious as to why these numbers exist. We, first of all, see that the number, if you take the number of times that an American visits a doctor in this country versus the number of times other citizens visit doctors in other countries, you see that an American visits a doctor a little over five times a year. In Japan, they visit a doctor 13 times a year. In Germany, 11 times a year, in Canada, 6.5 times a year. So it doesn't seem to be the anxiousness of American citizens to visit the doctor that causes that runaway health-care cost.

If you take a look at hospitalization rates, or hospital admission rates, 13.7 percent of the American population is admitted to the hospital in any given year. In Britain, it is 16 percent. Sweden, almost 20 percent. Germany, 21 percent. France, 23 percent. Still our costs far outstrip theirs.

If you take a look at the average length of stay in a hospital, in the United States—patient days per admission—about nine days. If you take a look at Canada, 14 days; the Swedes, 18 days; and Switzerland, 25 days. So it seems to me that there is something other than the patient's lust for medical service because of low deductibles or low-cost insurance that is causing the problems.

It seems to me that Mr. Matthews' analysis of the problem is like blaming the victim for the crime. And I do find that rather quaint.

I guess I would simply say that I think the American public will decide whether the President's plan, as it is proposed, reminds them of Stalin or reminds them of something a bit more constructive. And I think we know what the verdict will be on that.

But let me get back to the subject at hand, which is the problems associated with today's system. Mr. Feezor, you raised the question of genetic problems. One of the other hats I wear is as a member of the Health Appropriations Subcommittee. I have had a number of long conversations with Dr. Watson and others—Dr. Watson used to run the human genome project.

Let's say that we don't change the insurance system, and we complete the genome project at a cost of $3 billion to the U.S. taxpayer, so we begin to understand what lies at each point on the human genetic chain, and what diseases that predisposes each individual toward.

How do you think the insurance market will look 10 years from now if there are no significant changes, and what additional problems might persons who want to get insurance face just because the benefits of human and medical research have now given us some additional indication of who might get what at some later point in their lives?

MR. FEEZOR. Let me make one observation. I don't often make apologies for the insurance industry—they can do that on their own—but I do think it is necessary to look at it as larger than just insurance companies. Indeed, as the McGhan case has suggested, as we have seen a major employer in my state—one of the best ones with upwards of 100,000 employers—permanently excludes a preexisting condition for any dependent they insure for new employees coming in. And I am told that you have to sign a note to that effect.

So it is larger than just the insurance industry. I think we need to bring employers into the loop, who are in fact probably going to be one of the main focal points in which medical examinations, in order to qualify for some job, are probably going to be—that is, where that information is probably going to flow into the insurance and risk-profiling business.

I think that is one of the great dilemmas, with or without health-care reform, that we either at the state or at the federal level have to address. That is, are we going to allow the ability to profile risks, to be used by an employer or an insurer, to limit that person's access to reasonable health security or financial stability, in the case of life insurance, and that sort of thing. I think it is something that we need to address, like I said, with or without health-care reform.

To answer your question, 10 years from now, I think the ability to say that an Allen Feezor is very likely to have cancer, which is in fact the fate that I have to share—we will be able to predict this for my children, and I think we are going to have to guard against this information being abused.

REPRESENTATIVE OBEY. Just one other question on that line. I used to work with asbestos. I used to sand asbestos tile floors in the days before we knew that asbestos had killed 40 percent of the British shipyard workers who worked with it in World War II, for instance. I also smoked three packs of cigarettes a day.

Now, let's say that the completion of the genome project also reveals that I have certain other additional genetic predispositions toward cancer. If I were not lucky enough to be a Member of Congress and in the federal plan—they were required to take me—if I were an individual, self-employed businessman out there in the pit trying to make a living, what chance would I have in a nonrestricted insurance market, given the expansion of that knowledge to get insurance at reasonable rates 10 years from now?

MR. FEEZOR. At reasonable rates, probably you're chances are not good. Again, I don't want to overplay the impact of the state reforms, but they are not insignificant in terms of at least 40 states now guaranteeing some affordability, once you get in the system, of being able to continue that, at least between insured plans.

One of the games employers play is that you have a period in which you have to qualify, you have to work for the employer, before you even can qualify for benefits, and therefore can allow breaks in service. But I think the reforms do help in terms of guaranteed renewability, affordability, conversion and continuation, once you are lucky enough to get into the system, I think we are making substantial strides to keep you in there if you can afford it.

And further, I think the question of the rating reforms that have been enacted generally—and let me quickly say that they are for a small group, which doesn't deal with large employers, doesn't deal with over 50 or 100 employees,

and it does not in most cases deal with the single individual. Twenty states have enacted guaranteed availability of a product; and 40 states, the rating reforms. Like I say, if you are able to get it, at least it will be capping the amount relative to what your peers pay; whether that will be a reasonable amount is another matter. Given the current state of rating reform, you probably will not find that unless you have a very hefty retirement.

REPRESENTATIVE OBEY. Dr. Wennberg, you said in your statement, quote:

> ... safe for patients and in the public interests to place global restrictions on growth.

And you said that the fear that providing universal coverage would necessarily add to health-care costs is wrong. I would like you to again reiterate why you think it is wrong.

DR. WENNBERG. The reason that it is wrong is because, at the present moment, the resources that we need to provide the care that we know works and that patients want are so much less than the amount available—we have such excess capacity. It therefore is safe and in the public interest to seek global limits.

Now, I am not recommending any specific policies for seeking those limits; there are many ways of doing it. But the debate on health-care reform will need to focus on this one question: Do we interpret our present predicament, because of the result of unbridled medical progress and unbridled patient demand, resulting in such demand for services that we no longer can afford to provide what works and what patients want; or on the other hand, have se gotten ourselves so far down the slope of a supplier-induced economy that we have capacity way in excess of the amount required to provide those services?

The evidence that I have seen through the work epidemiologists and those who have looked at this situation really believe that we have massive excess capacity. When you held up your chart, for example, comparing the United States to other countries in terms of issues on utilization and asked the question. If demand is so great, why in some of these cases resources are less. I wish you had held up charts showing different cities in this country, because the twofold differences between the United Kingdom and the United States exist between Boston and New Haven, all around the country. The evidence is massively there in the databases that show such striking differences in the way that care is delivered between community A and community B, that consumers cannot be the source of this difference. Nor can a consensus of what works be the difference, because what works in Boston works in New Haven, yet what is delivered in one city is so different than the other.

So the statement that I make here about it being safe for patients and the public interest to place global restrictions on growth is based on this striking evidence that shows we have such different practice patterns from one place to the other; and when we begin to actually ask the question in places where patients are empowered to make choices, very often they choose less invasive treatments than were supplied under this economy, because they prefer to live with their situation rather than take the risks in many more examples than we have thought.

Second, when you look at the global relationships between investment rates of community A, B, C and D, and ask the question: Is there any evidence that spending more makes people live longer, the answer is no. We simply don't see that evidence.

But what we do see is, you have greater capacity in the acute hospital sector, more and more people are being, quote, "medicalized" during their year of life; they are being admitted to the hospital much more, dying in the hospital rather than at home or in hospices. And, yet, with evidence that all of this effort actually improves longevity, you will have to make some judgments about the quality of death, I guess. Some of us might prefer to do it at home.

REPRESENTATIVE OBEY. Let me ask you, Mr. Matthews. A little fun was made of the President's suggestion in his package that people be mandated to belong to certain health programs. Under the proposal that you have been pushing, isn't there a mandate in your own proposal?

MR. MATTHEWS. There is none in ours, no.

REPRESENTATIVE OBEY. There is no mandate to——

MR. MATTHEWS. There is no employer nor individual mandate.

REPRESENTATIVE OBEY. There is no mandate to invest in that IRA?

MR. MATTHEWS. No.

REPRESENTATIVE OBEY. Then what protection does society have in knowing that individuals will exercise a responsible choice individually so that they don't get left holding the tab if somebody who is 25 years old, working, and think that he or she is going to be healthy all of their life. So they don't invest in an IRA, they instead by a new car, and they get hit by a truck on the way out of the dealer's lot? What is to prevent Uncle Sam from winding up being the sucker then, or the taxpayer winding up being the sucker?

MR. MATTHEWS. Well, if the person has any assets, you system simply go after the assets.

REPRESENTATIVE OBEY. How many assets does a recent college graduate have?

MR. MATTHEWS. In many cases, not many, and that is why you have the public systems that I talked about for people to fall back on.

REPRESENTATIVE OBEY. But that will cost the taxpayer, right?

MR. MATTHEWS. My understanding of what Americans want to do is that they will probably want to have a safety net for the people who are——

REPRESENTATIVE OBEY. Irresponsible?

MR. MATTHEWS. Irresponsible, indigent, to some degree irresponsible. But you do have access to having those people either pay more in taxes ... you have penalties you can apply in there. And there has been one, since you asked about the ethics question, the head of the Ethics Department at the University of Tennessee——

REPRESENTATIVE OBEY. We are running a roll call, so I would prefer that you respond to the question I ask.

MR. MATTHEWS. Which I thought I had. I was just going to give an analogy on that.

REPRESENTATIVE OBEY. Well, I asked the question on ethics some time ago?

MR. MATTHEWS. Well, that is right. But I was just going to tell you that a medical ethicist at one of the major university hospitals has put forth a book saying, if a person chooses to take a skiing trip rather than buying health insurance, when the person enters the hospital and does not have the money, that person will be denied care.

That is not necessarily my position. I am saying that among medical ethicists, some are talking about that type of an approach.

REPRESENTATIVE OBEY. I guess I am not very impressed by the ethical result no matter how you slice it.

MR. MATTHEWS. Well, the person was arguing that if you make an autonomous decision as an individual to choose one action as opposed to another, then if you come up and we override your decision, you are essentially denying that person's autonomy. You are giving them the option to make a decision, and then you say we are going to come and support you even if you make the wrong decision; and that is the basis behind their thinking.

REPRESENTATIVE OBEY. No, you are simply describing the world that would exist under your proposal, not mine.

Mr. Starr, let me ask one last question. It has been my impression that one of the reasons that we have such a frustrating labyrinth of paperwork, conflicting rules and regulations, conflicting incentives, idiotic incentives, running at cross-purposes sometimes in this area, is precisely because we have followed the incremental approach for the last 40 years, rather than following the comprehensive reform approach.

We pass Medicare, and then we pass Medicaid. We provide some public health programs; we have the DRG system; and we have all kinds of these systems in which each attack a small piece of the problem, but without any comprehensive reform. And so you still have massive incentives for gaming, massive incentives for cost-shifting; and it seems to me that whether you like President's Clinton's prescription, or Congressman Chafee's, or Congressman Armey's, or Congressman Cox's, or anybody else's, at least if you want to reduce that blizzard of conflicting and sometimes perverse incentives, you have to deal with a comprehensive approach. And I take it that you agree with that, and I guess I would just like to get a response from you on that before I turn it over to Congressman Cox.

MR. STARR. Well, Mr. Chairman, we have succeeded very often in moving costs around without controlling them. When we have tried to control public programs, we have shifted the costs to private payers. When we have tried to control the costs of hospitals, we have succeeded in shifting costs to outpatient care.

Many of these piecemeal approaches simply underestimate the creativity of the providers to extract revenue; and unless we approach this comprehensively, unless we take a systematic view of it, we will not be able to bring costs under control.

I just want to say one thing in response to your last question to MR. MATTHEWS. In our country, when people are injured in an automobile accident, when they are seriously ill, yes, we do take care of them in an emergency. A decent society will not leave people dying in the streets. But a prudent society will have asked everyone to pay beforehand in the first place.

REPRESENTATIVE OBEY. Well, let me suggest ... two minutes left for a vote? Well, I think I will skip the vote. I am not going to try to be in two places at once.

I am sorry I interrupted you. Go ahead, finish.

MR. STARR. I was just saying, Mr. Chairman, that as a decent society, we don't leave people dying in the streets. But as a prudent society, we ought to

ask people in the first place to pay for health care. Everybody is going to need health care at some point or another.

It is like paying for the protection of the fire department in your town. Even if you don't use it one year, you need the standby presence of those facilities in your community; and you should pay your share toward the maintenance of that resource in your community.

And I think when we spread that cost fairly among people and among employers, then it will be more manageable for everyone.

REPRESENTATIVE OBEY. Let me ask Mr. Matthews. In your proposal, which you were defending in *Forbes*, what kind of a deductible do you have?

MR. MATTHEWS. The deductible we talk about normally is in the neighborhood of $2,500 to $3,000 on the policy. There are policies out there now as——

REPRESENTATIVE OBEY. How many households in the United States have $3,000 in cash available at any time?

MR. MATTHEWS. I don't know that figure. Probably not a great many would want to put to health care.

REPRESENTATIVE OBEY. Under U.S. Treasury data, 57 percent of U.S. households don't; and 51 percent of households with incomes between $30,000 and $40,000 don't in the Treasury study.

MR. MATTHEWS. That is why what we are suggesting——

REPRESENTATIVE OBEY. So how is that a real solution to people's——

MR. MATTHEWS. It is a real solution because the employer right now, in most cases, spends for a family policy ... the average cost of an employer-provided family policy runs about $4,200 to $4,300 a year. Many times the employee is putting in some of that as well.

What we are suggesting is that you not take extra money out, or that you just simply give the person a catastrophic policy, but that you take that same money and instead of giving that whole money to the insurance company, you put it in the Medical Savings Account.

REPRESENTATIVE OBEY. I understand what you are suggesting, but I guess my question is, if they don't have the money to do it in the first place, how is that going to help?

MR. MATTHEWS. Let me take your situation, right now, in the Federal Government. If they gave you the option and could put that same money that they are buying you a policy with now and put it into the a Medical Savings Account, you could buy your catastrophic policy in the neighborhood of $1,700. The money that is left over—we are looking at $2,500 or $2,600 —could go towards paying the deductible in that year.

Now, if you didn't use all of that money—and the vast majority of Americans wouldn't use all of that money—it would still be in the account the next year. Your employer would re-input the money; you would now have $5,000 in the account to cover that deductible.

REPRESENTATIVE OBEY. So there is a mandate for the employer?

MR. MATTHEWS. Not that the employer has to provide it, no. But we are giving people the option of saying, if you want to have standard health insurance, like you have it now, that is fine. But give me the option of putting the money into a Medical Savings Account and being able to keep a great deal of the money that is now going to the insurance companies.

REPRESENTATIVE OBEY. So you are telling me that there is not a mandate on the employer to, in fact, provide that money?

MR. MATTHEWS. No, there is no employer——

REPRESENTATIVE OBEY. There is no mandate on the part of the employee to actually put it into a medical account?

MR. MATTHEWS. No. What you have, under what we have been proposing, if you are looking at the *Forbes* article——

REPRESENTATIVE OBEY. So, if people behave the way you would like them to behave, the program will work; and if they don't, they will go to a public hospital, or not get treated?

MR. MATTHEWS. Under what we are supporting, the employer would take the same money and provide the employee with either the same policy that you have now—if you like the low deductible insurance, that is fine.

REPRESENTATIVE OBEY. You just said he would, but I asked you if there was a mandate.

MR. MATTHEWS. Under what we are proposing, there is not an employer mandate that the employer has to provide health insurance. There may very well be a proposal, a mandate, in which the employer says, if you provide health insurance, you have to give them three options—standard low-deductible, HMO or Medical Savings Account—and then let the employee choose.

REPRESENTATIVE OBEY. It sounds to me like a 19th century choice.

MR. MATTHEWS. Well, now, under the FEHBP, you have a choice yourself, do you not? You have a government-wide system, you have a number of union-type association plans, or you have HMOs, and I assume you are bright enough to be able to pick the one you like and the one you think would be best for you.

REPRESENTATIVE OBEY. But under your plan, people aren't required to. Under ours, we are.

MR. MATTHEWS. Under your plan, as a source of employment, they give you that option; but the Federal Government is not required, in essence, by law. They cover the people that are there, but it is not a mandate across the country.

What we are saying is that the employer——

REPRESENTATIVE OBEY. With all due respect, you are playing word games with me.

MR. MATTHEWS. I don't see how I am playing word games at all. Right now, under many businesses, employees have the option of either a low-deductible policy, or an HMO, or some type of PPO. They have choices now.

REPRESENTATIVE OBEY. With all due respect, that is not on point to my point. But that is all. I am really out of questions.

Congressman Cox, I think, is coming back. If I had known that roll call would go on that long, I would have gone over myself.

MR. FEEZOR. Mr. Chairman, if I might, I think one of the real problems that we have in trying to get enlightened about whether it is at the state level or federal level in health-care reform is the fact that the general public, and particularly, the business community, in the main, do not understand how we are currently paying and how the current system is costing us.

In my home state, the average hospital stay, which is running about $7,500, 30 to 31 percent of it is uncompensated care. That is not so bad. But as we look forward, by 1996, that will be $15,000, and 50 percent of it will be uncompensated care.

Now, we have some sophisticated purchasers, pretty good-sized banks in North Carolina—a few national banks are located there—that do a pretty good job. They get a 15 percent discount right off the top, but they are still on a horse that they can't ride.

What you have within the business community is probably an intellectual understanding that they can't control costs on their own, but there is a visceral distrust of government being able to do it better; and I think that is one hurdle.

But I think also, the current system—and I think it probably would be aggravated under the system proposed by Mr. Matthews—of uncompensated care and cost shifting are probably going to increase, what I call, the non-Medicare components of our system. It is going to increase administrative expenses and the number of accountants who can figure out that I have X amount of debt because of all the people who weren't prudent, and how to recalculate how we can maximize that with the 15 or 25 major payers that I do deal with. And I think therein lies a fundamental problem that, left unchecked, we are going to have to deal with.

But one other point is that I think if the average taxpayer knew how much their current burden is—I have seen some figures again in my home state of somewhere between $600 and $900 is the tax burden of the average family in North Carolina, $600 to $900 for uncompensated care and free care that is provided in government shortfalls and in government programs. And if you put that figure overtly up there on the table, you would have an awful lot of folks say, wait a minute, there has to be something better. But because we are not laying it up there on the counter, it is hidden in this morass of cross-subsidies. I would put forth the premise that the lack of understanding of both the cost and how it is financed in the current system is one of the biggest barriers that we have in our public debate.

REPRESENTATIVE OBEY. Let me ask one question of you, MR. STARR. Much has been made of the fact that the President's plan is going to require all employers, including small businesses, to provide health insurance; and people are saying that is going to be a burden on small businesses. And I think it is going to be a burden on small businesses; there is no question about it.

My family used to run a lot of businesses—a floor covering business, a restaurant business—I have seen it all. But let me ask you, can you tell us how small businesses fared, because two-thirds of them do provide coverage today to their employees. How do small businesses fare today in today's insurance market situation in comparison to what General Motors has to pay for a policy, or Chrysler or any large employer in my state? What are some of the pressures of the existing market system that are experienced by small businesses?

MR. STARR. Mr. Chairman, if there is one group that will truly benefit from reform, it is in fact small business. In today's market, small business pays the highest administrative cost for insurance; for firms with fewer than five workers, 40 cents out of every premium dollar goes to insurance administration. For firms between 25 and 50 workers, 25 cents on the premium dollar go for administration.

Reform enables small businesses to buy more health care for every dollar, because less will go to administration. The larger the company that buys the insurance, the lower the administrative cost. As you aggregate, as you combine businesses together in larger purchasing groups, they transfer to small businesses the kind of advantage that large firms now have.

Today, firms that buy insurance are bearing the huge burden of uncompensated care that Mr. Feezor described. He said 50 percent of the hospital bills in North Carolina in 1996 would come from uncompensated care. When you have universal coverage, you pull that out. The cost goes down for the small businesses that insure.

Today, we have experience rating; that is, each small firm is rated separately. And so, God forbid, if one employee has cancer, then the rates for that little company may go sky high. Under reform, with community rating, we will be able to prevent that from happening.

Today, the small-business owner has no leverage in the marketplace. Under reform, they get the buying power of AT&T. The caps on the contributions by small businesses under reform will really represent a windfall for small businesses.

You know, not having health insurance is no solution to the problem of high health-care costs. The children of employees who work for small businesses, they all get sick, they all have doctors' bills and hospital bills; and, of course, many of them are in fact terrified of losing everything. The owners themselves who don't have coverage are terrified of losing their businesses from high health-care costs. So reform gives them security. In a way, I think health-care reform will protect the assets of those small businesses that are now exposed in this current market.

REPRESENTATIVE OBEY. Thank you. Just one comment, and then I will turn you over to Congressman Cox. I thought the most outrageous example of what can happen under the existing system was brought to my attention by a constituent of mine who was a self-employed businessman in Ashland, Wisconsin on Lake Superior—not a very high-income town, one of the lowest income areas in my district.

He was a very well-known, prosperous businessman, went into the hospital, had a triple bypass, and when he got his next bill for his premium, it was for $12,000 a year. Now, I don't know many people in this society who can afford $12,000 premiums, but that is what he was asked to pay. And he had a choice.

People talk about choices. It is kind of like the choice the classical liberals in the 19th century said we had. You can work for a company, or you can choose not to work. So, you know, why should they join the union? This fellow had a choice, too. He could choose to pay or choose not to pay, a hell of a choice.

Congressman Cox.

REPRESENTATIVE COX. Thank you very much, Mr. Chairman.

I wonder if I could pick up on this notion of medical IRAs and ask each of you to address it in this context: When we talk about health-care insurance, we are not really talking about insurance at all, because as each of you have pointed out in one way or another during your testimony in response to questions, everyone can look forward to getting sick and/or dying eventually.

This is a certainty; it is not a risk in the sense of an automobile accident. We know that each of us will incur costs associated with illness and dying; it is just a matter of spreading those costs sensibly over our lifetimes. And the idea, it seems to me, is to encourage saving against that cost by society at large in a sensible way so that we amortize the cost rather than dealing with it as, for example, Congress deals with floods, waiting until they happen and paying the full amount in the current fiscal period.

Would a medical IRA which would permit people and indeed encourage them to sensibly amortize their health-care costs over their working lifetime be a good idea for that reason?

I will start on the left and work to the right with Dr. Wennberg.

DR. WENNBERG. I really don't have a lot to say about that. I haven't thought about the IRA problem, other than trying to fund my own; it is not medical.

What comes to mind here, however, is the idea of funding one's medical needs over one's own life expectancy is obviously highly unpredictable. And I have not looked carefully at the proposal that you are asking about.

But I would again direct your attention to the problem of the escalation in costs, which we are talking about, are largely supplier-induced. It has to do with the numbers of resources we make available in our communities. And the overcapacity of which I speak is largely in the acute sector. So large amounts of money put aside for catastrophic events which focus on the acute sector, could, in fact, have a very pernicious effect unless other controls are put in place of encouraging and expanding an already oversupplied sector of the health-care economy.

So these comments I make again are focused on the need we have to take a systematic look at what is going on in our health-care system and not to approach it just simply as a question of finance.

REPRESENTATIVE COX. I think you are precisely right, and for that reason I would think that medical IRAs would be only part of the solution; and as a supplement, they might provide some assistance to us, but that it is certainly not of itself a panacea.

Mr. Starr, you noted in your own testimony, no one on Earth is blessed forever with good health—that is a truism that I think everyone here can agree with—and also that those who refuse to pay for coverage ultimately shift the burden to someone else. At least many people are successful in doing that.

Why wouldn't a medical IRA be a means of ensuring that, at least to a substantial degree, people would not put their own costs on someone else's shoulders?

MR. STARR. Just to follow up on what Mr. Wennberg said, a policy that includes a deductible on the order of $2,500 or $3,000, which is what I think we are discussing, provides no coverage for preventive and primary care services, effectively, and so will keep expenditures low for the kinds of services that help keep people out of a hospital, that help keep them well.

On the other hand, once you get past that $3,000—if you are in the hospital for an average stay in North Carolina, it is $3,500, so you are going to get past that deductible with one health hospital stay—there is no restraint on health-care costs.

REPRESENTATIVE COX. I am sorry, I think your points are well taken, but I wonder if you could direct your analysis to the medical IRAs.

MR. STARR. That is exactly it. The medical IRAs encourage the purchase; in fact, they are designed to encourage the purchase of precisely these kinds of policies. And these policies result in a distribution of resources in the health-care system that is, to use Dr. Wennberg's word, pernicious. It produces a misallocation of resources towards the most high-cost services, and much less toward the preventive and primary care services that we really need to keep down costs for society as a whole.

REPRESENTATIVE COX. If I misunderstand you—correct me, but I think what you are saying is that people will treat money in their own IRAs as if it were someone else's, and they will prefer to buy expensive things to cheap things.

MR. STARR. No, once they are past this threshold and they have the coverage.

REPRESENTATIVE COX. You are talking about the insurance policy——

MR. STARR. If they are going to buy an insurance policy out of an IRA.

REPRESENTATIVE COX. You are talking about the insurance policy, not the IRA, you are talking about an insurance policy that works in that fashion?

MR. STARR. I hope you don't mean that people would have enough money in the account to pay for all of their health care, including catastrophic events.

REPRESENTATIVE COX. Let me give you an example. I have just read through at least the descriptive parts of the leaked Clinton plan, as published by BNA this morning; and they make it very clear that some things are covered and others aren't. And if you are mandated into a collective and you are required to buy one of these policies—and there is no place else to buy it but the collective—and the policy that you have chosen does not cover your particular problem, where is the money coming from to pay for that?

MR. STARR. Well, if you did read that, and I don't think we should be debating the specific provisions of that, because as everyone has said here, they are going to change——

REPRESENTATIVE COX. But as a general principle, the insurance plan will cover some things and not other things, and I am talking about the other things.

MR. STARR. There is a stop loss on the individual of $1,500, and for a family, $3,000, so the proposal limits costs just at the point where this other proposal suggests we begin coverage. So the degree of protection here——

REPRESENTATIVE COX. But the stop loss provision, if I might go on, means essentially that after $1,500, somebody else, the taxpayers, the government, pays for everything, precisely the problem you just pointed out.

MR. STARR. These are private health plans that must manage within the amount of money that they collect from premiums.

REPRESENTATIVE COX. And subsidies provided for low-income and small businesses, right?

MR. STARR. That is correct.

REPRESENTATIVE COX. Time is up.

MR. FEEZOR.

MR. FEEZOR. I think, Congressman, certainly the value of trying to promote greater individual responsibility in planning for one's health-care needs, which

is implicit in the IRA, is excellent and should be encouraged. Yet, at the same time, I hope I am not hearing you say that a family should be able to set aside the resources needed to amortize their health-care costs over a lifetime.

I come from a family that has had a six-way bypass, two episodes of cancer, most recently costing us $140,000 in one year; and with a father who never made more than $5,000 in a year in his entire life, there is no way on God's green Earth that we could have set aside that kind of money.

REPRESENTATIVE COX. While it is certainly not going to be true on a case-by-case basis that everyone can do that, it must certainly be true that, as a society, we can do that, because there is another source for the money, people that are working and coming up with earnings can provide funds. Whether it is for the government or for private insurers, it has to come from individuals setting aside that amount of money through taxes, through insurance payments, or what have you, over the course of a lifetime.

MR. FEEZOR. Certainly, and how you do that, I think, is maybe the million dollars question here—or maybe a trillion dollar question is more appropriate. If you are talking about an IRA coupled with insurance that would kick in at some level, an insurance mechanism, then I think the points made by Professor Starr are on target. That, in fact, once you pass that threshold, you are in a system that is very intensive and it has little restraint, or the restraints that we have, which is utilization management, and that sort of thing.

REPRESENTATIVE COX. Am I inferring from your comment that you would prefer that the medical IRA, therefore, be useful only for fee-for-service rather than insurance, that you shouldn't be able to buy insurance with the money in the medical——

MR. FEEZOR. Oh, no, I assume there would be freedom of choice in how one would employ that; so I think the real question on the IRA—and it is a field that I probably shouldn't venture into—is probably the tax equity issue, which of course is far disproportionate to those of us who are fortunate enough to be in a higher income than to those who aren't.

I would think that would certainly have to be addressed, at a minimum, and that probably those thresholds would also need to be somewhat income related, if you want to go down that path.

REPRESENTATIVE COX. I appreciate your comment.

MR. MATTHEWS.

MR. MATTHEWS. Yes. Let me just address several of the concerns raised on that, and I will start with preventive care, because that is sort of the big buzz word today is whether or not a policy provides preventive care.

As we are discussing medical IRAs or Medical Savings Accounts, we are talking about, instead of taking the money that we are providing, buying low-deductible insurance and buying high-deductible, and putting the premium savings in an account.

REPRESENTATIVE COX. Let me just stop you and ask you, your definition of this medical IRA program would put a constraint on what the individual could do with the money in the account, and it would restrict the use of the money in the account to the purchase of high-deductible rather than low-deductible insurance?

MR. MATTHEWS. No, not necessarily. The person could buy low-deductible or take it and go to an HMO with it. The person has free choice in terms of all the available options.

We think most people would choose the high-deductible insurance once they compared the cost of it. If they buy that, they have the money left over in the account, the premium savings that they had been paying for a low-deductible insurance policy; they can now use that for preventive care. You can include preventive care in the insurance policy, but the policy itself costs more.

Would people take money out of the medical IRA to purchase preventive care? I suspect most people would. Some people wouldn't for the same reason that I am sure Mr. Starr probably gets his oil changed every now and then in his car without having the auto insurance pay for it. You would have an account set aside for preventive care, because you want to protect against future catastrophe. So you have the money there for the preventive care.

But we need to understand that within one insurance company, for instance, 94 percent of their claims are under $3,000. What we are talking about is covering the vast majority of claims that are already being covered by insurance. If you want to reduce administrative waste, as Mr. Starr had been talking about earlier, with a medical IRA, the money goes directly out of my account to the provider, it doesn't go through the insurance company. The insurance company doesn't have to monitor it, process the claim, issue a check, none of that; it bypasses the administrative costs completely.

Supplier-induced demand. There has been a good bit said here that because of the supplier-induced demand that we have, the medical IRA simply wouldn't work. I would counter with, I have got two cars, one of which I have an extended service policy on, the other I don't. When my car that does not have an extended policy breaks down, I take it to the private mechanic. The private mechanic calls, tells me what needs to be done; if I have to have a lot of things done and they need to be done, we go ahead and do it, and we figure out how to pay for it.

When I take my other car to the dealership where I have my extended service policy—the last time I did they called and said, well, Mr. Matthews, your master cylinder is going out, it is not gone yet, but it is going out. Besides that, while we were under there, we found three or four things that we think are wrong that we think ought to be fixed, as well; and since it is only going to cost you $50 regardless of what we do, we suggest we go ahead and do it all.

And I said, fine; in fact, if you find anything else wrong, go ahead and fix that as well, because it is only going to cost me $50. I didn't scrutinize the bill to make sure they did everything; the total bill was $900. I thought I got a great deal. We simply did not scrutinize the bills.

Most people, when they get a hospital bill, pay no attention to it. That is the problem with the issue of the supplier-induced demand. We have all kinds of suppliers out there, including attorneys, plumbers and all other kinds of people, who want to induce demand from us; and because we are paying the bill in most cases, we are much more prudent.

REPRESENTATIVE COX. And yet we count on the insurer, do we not, in a market to monitor that underwriting risk, and the insurers are supposed to exercise pressure in keeping costs down?

MR. MATTHEWS. We are counting on the insurer. That tendency is growing as health insurance covers more and more things. And one last thing——

REPRESENTATIVE COX. I think Mr. Feezor also has a point on this. My own observation is that the less competition there is in the marketplace, the more bureaucratized insurance itself as an industry becomes, the less likely we are to get the benefits of competition, which is careful scrutiny of all of this stuff, since in an oligopoly at least, people can just spread those costs further.

And we see the limiting case with deposit insurance where there is a monopoly insurer of a very large risk, no expertise whatever in monitoring the risk, and the whole system collapses. I am afraid that if we put the Federal Government in that same position, in the field of medicine, with this national health board, we will again have the Federal Government, which has no expertise in monitoring underwriting risks, and in fact, by all appearances, an inefficient provider, monopolizing the field.

Mr. Feezor?

MR. FEEZOR. Well, two points. First off, the states will be happy to try and take some of that responsibility, since we have a little bit of expertise in that area, although there may be a mixed track record.

I heard you say that there would be a limit on what you could spend with the IRA monies. And I think Mr. Matthews was tweaking that proposal as a built-in, suggesting that, yes, I could take those monies and in fact purchase more comprehensive coverage or purchase HMO coverage.

I think that if that is the plan you are going to pursue, I would suggest that you go back and take a look at some of the experience between competing plans in the federal employee program, where when individuals are given a choice between high- or low-deductible options—there was a very clear difference in the risks—who selected the high options. And those people who thought they were going to need coverage ended up getting the high option plan, and that caused the high option plan to begin to really skyrocket and break apart. This is what we talked about a little earlier, the pooling of those risks to the point where those people who probably were in the most need of coverage continued to pay higher and higher costs because of the experience, and those people who were blessed with good health were able to pocket monies or had lower and lower expenditures.

And I think you have got to find—and of course there is a great deal of talk about risk adjustment factors. But I think you would have to guard against that in the system that is proposed.

REPRESENTATIVE COX. I will yield back to the Chairman for whatever further he wants to conduct, but I wonder if I might get you to address the trillion dollar question that you raised, which is how we are going to collect the money that is needed to pay for this?

Taxes as a point of collection provide one option; insurance premiums in either government-run or private operated insurance, so-called, plans—which are really just spreading the cost over periods—is another; and individual set-asides through medical IRAs are a third. And there are probably other permutations, and when you combine them together, still more.

What strikes me is the composition, and we know this in detail from census data of the 37 million uninsured; we know that the vast majority of them are in between jobs for less than a year—indeed, a majority, for less than four months.

We also know that a significant additional percentage comprise people who are dependents of unemployed people in those circumstances. So the number one predictor of whether you have health insurance or not is whether you have a job. If we can get you a job, we are most likely to get you health insurance.

Should we be concerned that in the Clinton proposal we are going to have an 80 percent tax—that is, 80 percent of the total cost at the point of employment—a tax on job creation as a means of solving a problem, the solution for which it seems to me is the creation of more employment, not less?

Mr. Feezor, since you have the most real-world experience with collection and regulation issues, I will start with you.

MR. FEEZOR. Well, I start with the premise that the source of the money is but one source, and that is the wealth of this country and its individual citizens. So the question is how we flow that money and whether we are purchasing effectively or purchasing desired value for that.

Let me say first off, I am not sure we can call the current system a private-payer system. If you look at the fact that employer-based private insurance probably ends up paying something less than 30 percent of the total health-care costs that are paid out in this country, it is a little bit of a euphemism to say that it is a private-sector program now.

REPRESENTATIVE COX. I would wholeheartedly agree.

MR. FEEZOR. One other observation. I think I would be concerned about the administrative costs. By that, I mean debt that is not going to pay for needed medical care—and yet at the same time, I can draw on my experience when I ran a 500,000-member self-funded plan, I did so on 1.8 percent of premium. That is pretty good; it even beats Medicare.

All that said was that I had an efficient claims paying operation. It didn't say one thing about what my other 98.2 cents of every dollar—whether I was getting good value or whether that was being spent in a prudent fashion.

Again, there is a lot of red tape, and we need to rechannel some of that money where we can achieve some honest efficiencies towards needed care, but also to look at what we are spending on care and whether that is necessary.

Congressman, I am ducking your question, I guess. If you had to ask me, because I have worked in it, I would think that the existing system, perhaps with a very fast evolution to fewer but more efficient payers who are able to provide value, and that is more cost-effective care—and I do think this is important—in a mandatory payment, or at least a mandatory funded mechanism, is where you end up having to go.

REPRESENTATIVE COX. Mr. Starr?

MR. STARR. I think you have to see health-care reform as a whole, as part of an overall plan to bring down the deficit, to bring down costs for the public—health-care costs for the public and for business as a whole; and that in that context, health-care reform will be good for economic growth, it will be good for jobs.

Today, there are many businesses that are paying tremendously inflated costs. We have talked about the cost of uncompensated care that gets shifted onto the businesses that are now paying the bill. Those businesses are also

paying for whole families. When that cost is spread among all employers, their costs will go down.

Many businesses will directly and immediately benefit from health-care reform; many more businesses will benefit from cost containment. The small businesses that insure—and I want to emphasize that the most rapidly growing small businesses in this country, the ones that are providing the most new jobs, do insure, but they face tremendously inflated costs in the current marketplace—their costs will come down and it will help them grow more.

Our manufacturing sector in this country bears tremendously increased costs. Typically, manufacturers are paying for the whole family—under a reform, that cost will now be spread—and the manufacturers are bearing tremendous costs for retirees. In both of those areas, we are going to see those companies immediately benefit from health-care reform. They will have lower costs, they will be able to grow faster, they will be able to provide more jobs. So I think, in all of these ways, we have a lot to gain economically from health-care reform.

We have to remember that all of the countries we compete with pay for health care. They all do. This is not going to be some special burden for American companies. And, in fact, even within our own country, Hawaii does require all employers to pay for health care. So employer participation in this system can be and will be consistent with economic growth and more jobs.

REPRESENTATIVE COX. I appreciate that.

Dr. Wennberg?

DR. WENNBERG. Well, I am not quite sure what the question is at this point.

REPRESENTATIVE COX. Let me restate it very briefly.

Over half of the 37 million unemployed are people who are out of work and in between jobs, the vast majority of them for less than four months, still a majority of less than a year. We can predict therefore that you are much more likely to get health insurance if you have a job. Is 80 percent of the total cost payroll tax on the employer a good way to create the jobs that are necessary to get people health insurance?

DR. WENNBERG. Well, again, I am not the economist at the table.

REPRESENTATIVE COX. I apologize. We are the Joint Economic Committee. We do ask questions like that.

DR. WENNBERG. But I am an epidemiologist and the person who has been interested in questions about, again, this peculiar problem that we have of such excess capacity, but we can't seem to get people into the system. And one of the points that I keep trying to make here is that the supply of resources that are already in the market are deployed to their maximum at this point, and yet when they are deployed at their maximum, we know that much of it is going into services for which there is little benefit and perhaps even harm.

The problem from a theoretical perspective is, how do we get the rest of the population into the system? And it is clear from the evidence that I have seen that increasing the size of the insured population to 100 percent will in fact not increase aggregate cost as long as supply doesn't go up; it will reduce costs for those that are now in the system, and that means that those that are now providing insurance will pay less for their own employees.

The question is how do you reallocate and how do you bring the rest of the people in? And I think that is what much of the debate is going to be about. But I want to try and set the stage for that debate by saying that it really isn't a problem of additional costs; it is a problem of redistribution of the existing burden for paying for the system, and the value that is now available to patients, in my opinion, will not be harmed by reducing utilization for those already insured.

So it is again my statement that it is safe in the public interest to pursue these policies. I want that to stand.

REPRESENTATIVE COX. Dr. Wennberg, the substance of your testimony on supplier-induced demand—which is a principal contribution I want to state, because you are expert on many things and you brought that expertise with you today. I just want to state that I find it enormously helpful, and I appreciate very much having this, and I certainly can agree—whether you call it supplier-induced demand or something else—that there is a whole lot of that in the system, and that is a principal part of the problem.

For illustrative purposes, I want to discuss a footnote in your testimony. You said:

> When neurosurgeons enter medical markets, they almost invariably find that the supply has already taken care of the demand for surgical management of brain tumors and head trauma. Neurosurgeons must thus invest most of their efforts in treating conditions for which there are valid, nonsurgical options.

It occurred to me, since we are not really discussing the role of lawyers in driving up not only medical malpractice costs, but the incidents of defensive medicine, that we might substitute lawyers in your example and see how it turns out. I have already substituted the word "collective" for "health-care alliance"; here is what happens when you substitute "lawyers" for "neurosurgeons."

Your footnote would read as follows:

> When lawyers enter legal markets they almost invariably find that the supply has already taken care of the demand for litigation. Lawyers must thus invest most of their efforts in generating cases for which there are valid, nonlitigation option.

I think that is also true. Thank you very much.

DR. WENNBERG. You are welcome.

REPRESENTATIVE COX. Mr. Matthews, did I neglect to ask you this question?

MR. MATTHEWS. I think so.

REPRESENTATIVE COX. I apologize.

MR. MATTHEWS. Did you want to ask me?

REPRESENTATIVE COX. The question is, first, I wonder if you could evaluate the assumption, that getting people a job is the best way to get them health insurance. That is the inference that I draw from the data. Of the 37 million uninsured Americans, over half are in between jobs for less than four months, and that more than that still are in between jobs for less than a year, and still more are simply unemployed.

MR. MATTHEWS. Well, all of that is correct. For better or worse, our system has evolved into an employer-provided health insurance system; and as you are suggesting, the best way to make sure a person under the system now has

health insurance is to make sure they either have a job, they are over 65, or they are very poor and female, and then they can get Medicaid.

REPRESENTATIVE COX. Now, accepting that assumption, the question is, will this 80 percent of payroll tax at the employer level help us to create those jobs for the people who don't now have them?

MR. MATTHEWS. Just the opposite; in fact, it will replace the 37 million uninsured with 37 million uninsured employed. What you have is a system where smaller employers will be forced to find out whether or not their employees can be productive enough to cover the cost of the health insurance.

Now, what the administration is doing, just to touch on this, is trying to come in with a fairly low-ball estimate saying, small employers will only have to pay, say, 3.5 percent of payroll. That will not pay anywhere near the cost of a policy. There is simply no way that the employer mandate that President Clinton is looking at now will solve the problem.

You could collectivize the whole system and do it with a single-payer system. It is amazing to me how, for instance, Mr. Starr seems to say that we are going to have, if we somehow or other collectivize this whole system, we get a whole lot more for a whole lot less, which I think Huey Reinhardt just mentioned, that under that kind of system, perhaps there really is a free lunch.

There is no way that you can do that kind of thing, give people a whole lot more services and have it cost less. The problem with the Clinton Administration plan right now is that there is no way to pay for the plan, and that is why it probably will be bogged down in Congress for some time.

REPRESENTATIVE COX. I appreciate that. I feel as if I should give Mr. Starr the chance to reply, but——

MR. MATTHEWS. It was a friendly attack.

REPRESENTATIVE COX. Perhaps I should.

MR. STARR. I think, if you have been following what Dr. Wennberg has been saying, it really contradicts what Mr. Matthews is saying. What Dr. Wennberg is saying is that we have more than enough capacity in the system—we have the hospitals, we have the doctors—and basically what we see is that in those areas which have the highest capacity, we have very significant overutilization; and consequently, it is possible within our available supply to provide coverage for these additional people.

Remember what Mr. Feezor said about what is going on in North Carolina. In 1996, it is projected that 50 percent of the bills from hospital will come from uncompensated care. We are already providing service to these people. But that means, in fact, we can bring them in because we are already devoting significant resources to them, and the additional cost involved is manageable.

The additional cost is not that great and can be offset by the kinds of savings that many of us believe will come from competition within those health alliances that you have been describing as "collective." Those alliances are a means of organizing and stimulating competition among private health plans.

They are all competing around the same benefit package, but that is important. It enables consumers to compare prices; it enables them to say, look what this plan is offering versus another plan—same package of benefits, but I can get those benefits from another plan for less; and if I choose that other plan, I get to save the money.

This is where the incentives come in that Mr. Matthews has been talking about. They come in at the point of choosing a plan.

REPRESENTATIVE COX. As I stated earlier on that point, my concern is that within my collective, I only get to pick, unless I am lucky—in a big area of perhaps Chicago or L.A. where I might get more choices, the law is only going to mandate that there be one fee-for-service plan; and if I am like most Americans and I like being able to select my own doctor, what I am going to end up with is a monopoly fee-for-service insurance plan. I will not be able to buy it from anywhere else and there will only be one. At best, I will get Medicare; at worst, HMO.

REPRESENTATIVE COX. Mr. Matthews, do you want to wrap up at all?

MR. MATTHEWS. There is an example going on out there under the Federal Employees Health Benefits Program, similar to what you are talking about, I think, where you have several plans supposedly competing. Virtually everyone who is familiar with the FEHBP feels that it is a system in need of great reform — there is almost no competition going on. Reggie Jones, who manages it, has told me that he has tried to remove most of the incentives to try and choose one plan or the other; he basically wants to have one plan that all of the providers are employing.

I talked to Aetna and when the FEHBP was originally created, Congress mandated two system-wide providers. There was Blue Cross and Aetna. Aetna got out of the system in 1989; and as they told me, they finally decided to get out one year when they broke even. They knew it was an omen from God to get out when they finally broke even one year.

What you have is the plans actually leaving the FEHBP because of the problem in there. It is not the kind of system that we want to expand for the country as a whole, because it is replete with problems, and Congress is even looking at trying to redress some of those problems right now. There is virtually no competition going on in there. You do have a choice, but it is very little choice, to amount to anything.

REPRESENTATIVE COX. The Chairman has been generous, and I would, subject to his structuring of the remaining time, I would yield back in any case.

REPRESENTATIVE OBEY. Well, I am going to wrap it up.

REPRESENTATIVE COX. Okay. Thank you, Mr. Chairman.

By the way, I want to thank the panel. This has been very, very helpful.

REPRESENTATIVE OBEY. In closing, I would just like to observe that as you have described some of the underwriting techniques the insurance industry uses to provide insurance, I am struck by the thought that so often these days what we can do that is clever isn't necessarily something that is useful, or even right, either economically or ethically, in my view.

I would also simply say that I don't know where the impression comes from that most of the persons who are uninsured are in the families of persons who are unemployed. That is certainly not my understanding. Most of the families that are not insured, in fact, have breadwinners who are employed.

Third, I would simply say that we can substitute words for other words in texts and that may be funny, but that doesn't necessarily mean that you are in fact describing what it is you are reading or attacking. And as far as collectives are concerned, it seems to me, and as far as choice is concerned, right now, I would not want to overestimate the choice that a lot of workers have

under the existing system. Because the choice they have is simply to like the plan being provided by their employer or not; and the only choice that many businesses have is to swallow whatever rating system they are given by the company doing their insuring, unless they are big enough to have some market impact on the price that they are being charged for the product.

So I think we can often find an awful lot of theoretical choice that doesn't really break down to real choice in real life circumstances. And I think the challenge under whatever plan that we eventually pass is to try to extend that choice, not in theoretical ways, but in real ways; and not in ways which are fascinating, but in ways which are equitable. And if we can do that, then I suspect, on a major issue, we will do what people sent us here to do.

Gentlemen, I thank you all for your time. I appreciate it.

[Whereupon, at 12:05 p.m., the Committee adjourned, subject to the call of the Chair.]

SUBMISSIONS FOR THE RECORD

LETTER FROM THE HONORABLE LAURA D'ANDREA TYSON, CHAIRMAN

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

THE CHAIRMAN

September 13, 1993

Dear Mr. Chairman:

I write with genuine disappointment to inform you that I will not be able to participate in The Joint Economic Committee's September 14 hearing on the health care crisis and its impact on the American economy. While I very much appreciate your invitation to testify, and share your concerns as to the consequences of not reforming the American health care system, the White House prefers to defer official testimony on health care issues until after the President formally announces his health care plan to the nation on September 22. In addition, CEA commitments related to the Administration's official rollout of the NAFTA initiative, also scheduled for September 14, present several direct scheduling conflicts with the hearing.

I look forward to presenting testimony to the JEC on the nation's health care crisis and the President's health care plan in the near future. The CEA is very proud of its special and longstanding relationship with the JEC; we will continue to work with you on the challenging economic issues facing the country.

Sincerely,

Laura D'Andrea Tyson

Laura D'Andrea Tyson

The Honorable David R. Obey
Chairman
Joint Economic Committee
Dirksen Senate Office Building, Rm G-01
Washington, D.C. 20510-8002

WRITTEN OPENING STATEMENT OF SENATOR CRAIG

Mr. Chairman, I am pleased to see the Joint Economic Committee take a closer look at economic issues surrounding health care reform. We hear a great deal about the increasing cost of care, the number of dollars spent annually and the effect this all has on individuals and families. But, there is also another side to this equation that deserves attention and further discussion and that is effect all this has on our economy. I look forward to hearing from our witnesses on this issue.

I have been involved in the health care reform issue. I have held two conferences on health care in my state over the last few years, which provided me with excellent feedback from the many Idahoans that attended. I have also participated in the senate as a member of the republican health care task force. Under the excellent leadership of Senator Chafee, we spent a great deal of time reviewing all aspects of health care, and made ourselves familiar not only with the problems surrounding our current system, but the various ideas being proposed to resolve them. One issue that greatly interested me, on the positive side of this issue, is the strength of the health care industry and its contribution to our economy.

Out of curiosity, after hearing a few figures nationally on the health care industry, i decided to take a look at this industry in Idaho. I was already familiar with the importance of our rural hospitals and health care providers and the roles they play in dour small rural communities, providing care, jobs, and supporting the local economy. without access to health care, communities suffer because it makes it difficult to recruit new businesses. in other words, health care is more that just taking care of people, and health care reform must take that into account.

In Idaho, for example, the health care industry is an important provider of jobs. Let me share some statistics (note that none of these figures include the insurance industry):

The health industry represented 4.4% of the gross Idaho state product in 1989. (that is the most recent figure the state could provide.) the health care industry generates $725 million out of a total of approximately $16.3 billion state economy. Remember, these figures don't include health insurance.

In 1992, there were 25,031 jobs in health services, out of a total of 416,283 jobs.

Jobs in the health care industry in Idaho also are generally above average on pay and benefits. For example:

Annual Average Number of Units, Employment and Annual Wages in the Health Services Sector of Idaho's Economy, October 1991 - September 1992

	Avg. Firms	Avg. # Emp.	Total Wages	Avg. Wage
Federal	6	700	$ 22,265,397	$31,808
State	11	617	$ 14,453,589	$23,426
Local	35	5,154	$ 96,153,068	$18,656
Private	1,807	24,599	$576,076,332	$23,419
Totals	1,859	31,070	$708,948,386	$22,818

SOURCE: ES-202, Report of Covered Employment and Wages, Idaho Department of Employment, Research and Analysis Bureau, March 30, 1993.

Mr. Chairman, these figures may seem minor to some, but in a very sparsely populated state like Idaho, they represent a significant contribution to the state's economy. I think it is important to note that health care reform will not only affect people's health care, but may also affect their jobs or their communities; and not all

these jobs we are talking about are doctors and hospital administrators. They are also nurses, food services, cleaners, staff assistants, and many others.

Mr. Chairman, let me be clear, I am not saying that we should do nothing; to do nothing would also harm our economy. the system has problems. However, as we discuss and debate this issue, we cannot do it in a vacuum. We need to be aware of both sides of this issue and look for ways of improving our system while keeping in mind that we are affecting a significant portion of our economy.

Some areas that I feel are very important are:

COST CONTAINMENT - One of the main forces driving health care reform is skyrocketing costs. Any health care reform proposal should include cost containment provisions that will help to control costs especially in the long-term. Short-term reductions will be difficult. Putting the individual in the driver's seat, so that he or she can make consumer-wise decisions on health care, will help to bring costs down.

PORTABILITY - Individuals should not fear that if they lose their jobs they will lose their health insurance. Insurance belongs to the individual and should move with the individual.

UIVERSAL ACCESS - Everyone should have access to health care. in addition to making health care affordable, this must also include the availability of a qualified health care provider in "frontier" areas as well as our large cities.

STATE FLEXIBILITY - There must be flexibility for states. It is difficult to prescribe a national cure to any problem and rural states often end up taking cuts.

MALPRACTICE - Malpractice reforms are needed -- for example, incentives for states to adopt out-of-court arbitration. I am looking at changing the allowance for punitive damages so that awards go toward improving the quality of care rather than the individual.

ANTI-TRUST - Anti-trust reform is especially important in rural areas. We currently waste scarce dollars because certain business relationships are illegal under the current code. This unnecessary waste needs to be ended.

RETAINS PRIVATE SECTOR - I am opposed to increasing the government's involvement in health care. The current level of governmental involvement is one of the factors that has contributed to the current problem. Cost shifting from public to private payers is a problem, yet public sector costs continue to rise more drastically than private sector costs. A study released by the National Center for Policy Analysis noted that government spending is rising three times faster than private spending. in other words, government policies are pushing up health care costs. Since the private sector has been working successfully for the majority of the population, it would be unwise to throw all of it out. Let's not forget that once we kill the private sector, it's gone forever.

LONG-TERM CARE - In order to get Medicaid costs under control, we must have some answer to long-term care. I am supportive of encouraging the development of private sector policies that would cover a six month or 12 month period. This would provide a great deal of relief to Medicaid. In addition, we need to look into tightening our laws dealing with divestiture of assets. Many people divest their assets and then let the government pick up the tab for the long-term care.

MEDICAL SAVINGS ACCOUNT (MSA) - This is a great way to get the individual more involved in his or her health care, and to be more aware of the cost of that care. The basis of this idea is that people would buy high-deductible catastrophic policies and put the money they save in premiums into an MSA. That money would earn interest tax-free and could be used for out-of-pocket expenses. If a catastrophic illness hit, or an accident, the money from the account could cover the deductible. If not, the individual has money to carry over for the next year. In the long-term, this account could provide funding for long-term care.

These are just some of the things that I have been looking at as ways to resolve the problems with our current system, help control rising costs, make health coverage

more affordable and increase access. There is a great deal more that can be said, but in the interest of time, I will conclude.

Mr. Chairman, the American people have a great task ahead of them, because this decision will require the participation of all of us. The hearing today is a step in the right direction to review the need for health care reform and the economic and social problems that currently exist. I look forward to hearing from our witnesses today and tomorrow, and to learn from their expertise and experiences.

WRITTEN OPENING STATEMENT OF REPRESENTATIVE RAMSTAD

Mr. Chairman, I strongly applaud you for holding this important hearing on one of the most critical issues facing the workers, families and businesses of our nation.

I certainly hope you will continue to hold hearings like this as we begin in earnest to consider health care reform legislation.

I must register my deep disappointment that Dr. Laura Tyson, the chair of President Clinton's Council of Economic Advisors, was unable to attend this hearing. I was equally disappointed the Joint Economic Committee did not hold a single hearing on President Clinton's tax bill in the five and a half months from the time he announced his plan in February to the time Congress narrowly passed the measure in August.

I strongly urge the chairman to avoid using the same strategy during the health care debate. Of all the committees, the JEC should be a key facilitator of the discussion on this important issue.

I must also say I am deeply concerned about those details of the Administration's proposal that I've seen. The Administration's plan will require all small employers to pay 80% of the premiums of their employees' health insurance. These premiums -- essentially a hidden tax -- could literally drive small businesses out of business and destroy hundreds of thousands of jobs.

The ability of large companies -- those with over 5000 employees -- to opt out of this system makes the employer mandate-based system even more onerous for the small business owner. That's because the uninsured, Medicare and workers' compensation costs all will be rolled into the employer mandated system. As the Fortune 500s are opting out, the small businesses that do not enjoy that option will be footing the bill for their own employees. the uninsured. Medicare recipients and worker's compensation -- all through their premium payments!

A recent study of the economic impact of the Clinton Administration's proposed mandate on employers said the mandates will lead to the loss of 3.1 million jobs nationwide. The study was conducted by professors June and Dave O'Neill, both highly respected labor economists from Baruch College.

Last year we heard the Democrat leadership talk about a "Play or Pay" plan -- which meant employers either had to cover their employees or pay steep penalties. The Clinton plan should be called "Play AND Pay."

Regardless of how efficiently employers can cover their workers' insurance costs, they will be forced to buy coverage from a monopoly "regional health alliance" and pay government-determined premium prices. This will drive costs up and reduce the quality of care available to workers.

If small companies go out of business or lay off workers because they cannot afford the premiums, more individuals will fall into the "uninsured" category. This means the remaining small businesses will face even higher premiums because they are expected to cover the uninsured. As costs rise higher, more businesses will lay off workers or shut down. Pretty quickly, premium costs will skyrocket and literally bankrupt our economy.

We all know that without a thriving small business sector, our economy will never grow. That's why I was absolutely astounded when, during a health care briefing before the Small Business Committee, Hillary Rodham Clinton responded to a question from one of my Democrat colleagues who expressed

concern about the impact of the plan on small business by saying, "I can't go out and save every undercapitalized entrepreneur in America."

Mr. Chairman, this apparent disregard for jobs and small businesses in our country is shocking. We will never be able to expand health care coverage to the millions of uninsured Americans if the plan kills the small business sector of our economy.

I am also extremely concerned about the absence of significant cost containment provisions in the Administration's proposal. Two glaring contributors to rising health care costs -- burden some state mandates and skyrocketing administrative costs -- simply were not addressed by the Task Force.

Under the plan, administrative costs will rise even more and the source of expensive mandates will simply shift from the state government to the federal government.

Mr. Chairman, we need a comprehensive cost containment strategy that includes reforming the medical malpractice system to eliminate the need for expensive "defensive medicine;" streamlining unnecessary administrative costs; and preempting burdensome state mandates on health insurance, which add unnecessary costs to all health insurance policies.

Again, I thank you for holding this hearing. I very much look forward to working with my colleagues to address the astronomical rise in health care costs in a way that preserves consumer choice and protects the vital small business sector of our economy.

PREPARED STATEMENT OF PAUL STARR

Mr. chairman, you can measure the health care crisis in numbers, and you can hear it in stories.

The numbers are striking:

- One out of every four Americans under age 65 loses health insurance coverage over a two- year period; many others discover their insurance is inadequate when they get seriously ill. The problem of inadequate coverage, therefore, is not just that 37 million Americans are uninsured at any one point in time. It is the gnawing insecurity for millions of other Americans who cannot be certain their health coverage is solid and sure.
- Since 1980 the health sector has gobbled up an additional l percent of gross domestic product (GDP) every 35 months. That kind of spiraling growth is unparalleled in any other country. In 1991, the leading industrialized nations spent an average of 7.9 percent of GDP on health care, compared to America's 13.2 percent that year. Our spending continues to rise more quickly and is projected to hit at least 17 percent by the en of the decade.
- Higher costs to the nation naturally mean higher costs to the individual. In 1991, health services cost Americans an average of $2,868 per person, while costing Germans an average of only $1,659. During the 1980s, the costs of health care grew more than twice as fast in the U.S. as in Germany.
- Of current spending, between 20 and 30 percent is estimated by leading experts to be unnecessary and of no benefit to patients. Perhaps the most appalling waste is high administrative costs. For the smallest businesses, forty cents of the premium dollar go to insurance administration. Our system also suffers from excess capacity in hospitals (four out of ten beds are empty on a typical day), and excessive specialization among physicians (while other industrialized countries have half their doctors in primary care, we have fewer than a third, and the number of medical graduates in 1992 going into general medicine was just 14.2 percent).

But, for many Americans, the health care crisis isn't a matter of numbers like these: it's the story of their lives.

It's the story of the family that loses its coverage when the husband's company "downsizes" and his job vanishes.

It's the story of the young woman who'd like to quit her job and start her own company. But she can't: with her history of cancer, she'd never get health insurance on her own.

It's the story of the single parent on welfare who'd like to take a paying job. But if she takes the job, she'll have no health benefits, and her son has chronic asthma.

It's the story of millions of small business owners who want to buy health insurance for themselves, their families, and their employees--but can't get coverage at an affordable price.

It's the story of America's largest corporations, which are bearing two huge extra burdens: a big cost-shift from the uninsured (as hospitals recoup uncompensated care by raising charges to the insured) and ballooning health costs for their retirees.

It's the story of governors who don't have enough money for public infrastructure and other needs because every year Medicaid eats up any extra discretionary funds.

And, yes, it's even the story of members of congress who would like to cut the deficit or cut taxes--but are stymied by the prospect of rising health care costs that threaten our nation's solvency.

Americans in all walks of life, regardless of political party, need reform in health care. For some, their health is at stake. For others, their peace of mind is at stake. For all of us, our national economic interest is at stake.

Trends, however, are never fate: the numbers and the stories can change; the dynamic of spiraling health costs and eroding health security can be broken. But to break the cycle requires comprehensive reform in both the public and private institutions that finance and organize health care.

I want to emphasize today two aspects of the problem.

The first concerns the recent evolution of health insurance, as the industry has "segmented" Americans into risk groups and denied coverage to many people thought to be high-risk. Health insurance used to spread risk; increasingly, health insurers have sought to avoid risk. The industry's efforts to avoid risks, rather than to control medical costs, have been at the root of growing insecurity about health care. Reform must reverse this pattern, encouraging health plans to control costs and give their members the best value for their money, rather than screening out risky people.

The second aspect concerns the incentives facing doctors, patients, and managers of health care organizations. Incentives favoring higher costs have long been built into our system, and we have had no effective countervailing force. This imbalance is critical to understanding why costs have exploded here in the United States. Reform must correct that imbalance, creating the incentives for value-conscious choice and the countervailing pressure to keep costs down.

HOW HEALTH INSURANCE BECAME HEALTH "UNSURANCE"

When the health insurance industry first emerged in the 1930s, the pioneer nonprofit Blue cross and Blue Shield plans offered premiums to employee groups at the same price, or "community rate," no matter what their health, occupation, or other characteristics.

Over the years, however, commercial health insurance companies attracted many younger, lower-risk employee groups by offering premiums based on their experience. This system, called "experience rating," eventually forced the Blue cross plans to abandon or limit community rating to avoid being left with the highest-cost populations.

The spread of experience rating made it increasingly difficult for insurers to offer affordable coverage to the groups that predictably experience the highest medical costs. With the enactment of Medicare and Medicaid in 1965, the government assumed responsibility for providing coverage to the elderly, the severely disabled, and many of the poor. The public programs of the 1960s thus closed some of the most serious gaps left by employment-based private insurance.

Still, millions of other Americans could qualify neither for favorable group rates nor for any governmental program. They remained uninsured or could purchase individual or small-group coverage only at a relatively high price for the protection afforded.

The recent development of the insurance market has aggravated the insecurities facing people who have been stuck in the individual and small-group insurance markets. As health care costs have risen, health insurers have introduced a series of practices that have widened the difference in rates offered to consumers depending on their health and other statistically related characteristics. Such practices have reduced the quality of coverage available to individuals or small businesses or effectively priced them out of the market.

- Exclusions of pre-existing conditions are perhaps the best known of these insurance practices. Insurers use such clauses to deny coverage of particular

conditions or to deny any coverage at all to someone with a history of serious illness. With the rise of genetic screening, insurers may take the concept of pre-existing conditions a step further. They will increasingly be able to exclude individuals who have never been sick but are biologically at high risk of developing a costly illness.

- A second way to avoid risk is to "redline" occupations and industries--that is, to deny coverage to all groups or individuals in fields known to be hazardous or thought likely to attract people who are either unhealthy or high users of medical care.
- A third way to avoid risk is to refuse to renew policies of people with high claims, or (whether or not legal) to reduce or cancel policies abruptly when subscribers submit claims.
- Insurers can also screen out risks through more subtle practices known as durational and tier rating. Under durational rating, insurers offer below-average premium rates to new policyholders and then step up rates with above-average increases. The insurers know that people who pass a medical examination will have relatively low claims in the first year, primarily because applicants with chronic or expensive illnesses are not offered coverage. However, in succeeding years, as subscribers develop new medical conditions, their claims will rise. Thus, the insurers plan above-average rate increases. Tier rating is the practice of dividing subscribers according to their claims, and imposing stiff rate increases on those with the greatest claims. The combination of durational and tier rating effectively drives the sickest people out of the risk pool.

Illness can strike any of us at any time. That is why we need insurance. But the insurance system today often penalizes many of us for the misfortune of ill health. The system denies affordable coverage to people who desperately need it. It may exclude us even if we are healthy but happen to work in an occupation thought to be above average in risk. The term "insurance" is supposed to convey peace of mind. Health insurance in America has ceased to be insurance in the full sense of that word.

THE SOURCES OF THE HEALTH CARE COST EXPLOSION

As health care costs began to rise in the 1970s, some analysts suggested that this was merely an inevitable feature of a post-industrial society--as natural as the shift from agriculture to manufacturing in the nineteenth century.

But as health costs in the U.S. have soared above levels abroad, it has become clear that the cause lies in distinctive features of our health care system. Some attribute our high costs to aging. But, in fact, other Western countries have higher proportions of their population over age 65.

Some attribute our high costs to malpractice litigation and defensive medicine. But malpractice insurance costs are too small a proportion of overall costs to be a principal explanation, and even the most sizable estimates of the costs of defensive medicine do not account for a significant share of the difference in costs between the U.S. and other Western countries. Moreover, most of the practices adopted "defensively" are profitable: Would providers simply allow their revenues to drop if malpractice litigation were totally eliminated?

The sources of our rapidly escalating costs lie elsewhere. The incentives for both consumers and providers under our insurance system have promoted the most costly practices. And, for nearly half a century, public policy has amplified the effect of those incentives, expanding hospital construction, medical research, and medical education with little view toward the ultimate impact of enlarged supply on cost.

These two forces--unconstrained fee-for-service insurance, plus publicly financed expansion of capacity--have set off the cost spiral that is pushing health care up to 15 percent of GDP and higher.

By its nature, insurance reduces the sensitivity of consumers to price. But, in the case of health insurance, the impact on the providers of services may be even more important. Much of the spending for health care is uncontrollable by individual consumers. A patient in a hospital generally does not have enough information or confidence to reject recommended treatments in favor of cheaper alternatives.

To be sure, consumers make some key decisions, such as when to seek health care in the first place. But physicians and other health care providers generally determine whether diagnostic tests, surgery, or follow-up visits are necessary. In other words, in health care, unlike other industries, the *suppliers* have a lot of control over the *demand* for services, especially the institutional and technical services that are most expensive. Much research has shown that when providers have more time on hand or more hospital beds available, services and expenditures increase. Health care economists refer to this effect as "supplier-induced demand."

Only in part is this the result of the suppliers' self- interest in providing more services. In health care, the suppliers of services often do not know what works, and they respond to their uncertainty by erring on the side of aggressive intervention. In the decades after the Second World War, as public policy fostered the growth of hospitals and increased the supply of physicians (notably specialists), it encouraged the adoption of the most costly, resource-intensive patterns of medical practice.

These patterns cannot be changed overnight: they are built into the very physical structure of medical facilities and the career choices of professionals. But we can begin to establish a new system that encourages consumers and providers alike to make careful, value-conscious choices about the care that truly serves the patients' interests.

THE PATH TO A SOLUTION

In broad terms, there are at least five things we need to do.

First, to restore and extend health security, we need to change the way insurance works. The economic rewards must not go to the health insurance plan that avoids sick people, but to the health plan that produces the best value for all consumers, whatever their health. That means eliminating any advantage from risk selection (skimming off the healthiest people). It means setting new rules for health insurance:

- community rating--that is, equal rates to all consumers, regardless of their personal characteristics;
- open enrollment among health plans;
- no exclusions of preexisting conditions;
- risk-adjusted payment to the health plans.

Second, to control costs, we need to clarify the choices and change the incentives facing consumers and providers and to set clear limits on the rate at which the system as a whole can grow. consumers should be able to choose among alternative plans and to reap the savings from a plan that delivers high-quality care at a lower cost. Empowering consumers will stimulate competition and help to hold down costs. However, many areas will lack competing plans; moreover, the industry has a long history of

monopolistic practices. Thus, to ensure that costs are controlled, we need the backstop of a regional limit on the rate of premium increases.

Third, to maintain and improve the quality of care, we need a stronger emphasis on primary care and prevention and a systematic effort to improve the knowledge of both patients and physicians about what works. consumers need better information about the quality of care among the alternative plans and providers they may want to consult and what kind of treatment fits their needs. Providers need better evaluative research on the outcomes of alternative treatments. Holding plans and providers accountable for their quality of care by publishing measures of consumer satisfaction, as well as the appropriateness and outcomes of care, will also spur them to improve their performance.

Fourth, to make the system simpler and more patient- and provider-friendly, we need to standardize coverage, claims, and many other aspects of the system and apply the same easy-to-use technologies that enable us to complete a credit card transaction anywhere in the country in a few seconds. Today's paper-clogged insurance system is a relic of another age that not only increases our costs and steals our time but takes doctors and nurses away from their true calling--the care of patients.

Finally, we need to insist on our mutual responsibilities in paying for health care. No one on earth is blessed forever with good health; those who refuse to pay for coverage ultimately shift the burden to someone else. The burden will be more manageable for everyone if it is spread fairly and controlled.

Mr. Chairman, I appreciate the opportunity to appear at this hearing, and I will be glad to respond to any questions as best I can.

PREPARED STATEMENT OF JOHN E. WENNBERG, M.D., M.P.H.

Thank you for the opportumty to testify on the health care crisis in America.

The economic consequences of failing to deal with undisciplined growth of the health care sector are enormous. But the ethical implications are even more important: at the heart of the crisis is a runaway medical care technology and an increasing specialization of the professional work force which favor ever increasing rates of medical intervention without evidence that more care is better or wanted by patients. The assumptions that the health care crisis results from medical progress and the demand of patients for invasive, high tech medical care are wrong. The crisis stems from fundamental flaws in the ethical and scientific basis for clinical decisionmaking:

- The risks and benefits of most medical interventions are poorly understood, particularly from the point of view of the outcomes that matter to patients. Although investments in basic biomedical science and applied technologies have greatly increased the power to intervene in the natural history of disease, investments in the evaluative sciences to clarify the risks and benefits of these interventions are inadequate.
- The traditional model for the doctor-patient relationship encourages patients to delegate decisionmaking responsibility to the physician. Most conditions, however, have more than one clinically valid treatment and each has a different set of risks and benefits. Patients differ in how they value these outcomes. The prescribing physician's own preferences for treatments and outcomes, rather than the patient's, often determine which treatment is used.

These flaws set the stage for an economy dominated by supplier-induced demand. Medicine's untested and often conflicting theories of efficacy and the dominance of professional preferences ensure the full deployment of available resources, no matter what the quantities. Spiraling costs emerge as the inevitable consequence of the policies of growth that have prevailed in the U.S. health care sector since the 1960's. Policies that support the open-ended financing of care based on fee-for-service provide much of the fuel and the federal government, through its Medicare program, has contributed substantially. I am confident that the systems of finance will hold front stage in the debate over health care reform. In this testimony, I highlight policies in two other areas that have contributed in substantial ways to the dynamics of undisciplined growth in the health care sector:

- there has been a failure of federal science policy to assure the orderly development of the scientific basis of clinical medicine; and
- government programs have increased the supply of physicians and promoted the specialization of the physician work force into technology-driven subspecialties whose workloads favor invasive treatments.

The end result is a level of investment in acute hospitals and specialists well in excess of the amount required to produce and deliver services that are known to work and that patients are known to want.

Variations, Outcomes and Patient Preferences

Variations, outcomes and preference research provide the empirical evidence in support of my thesis that supplier-induced demand is at the heart of health care economic and ethical crisis.

Variations

Virtually every medical condition can be treated in more than one way. For many conditions, there are medical as well as surgical treatments that are appropriate. Watchful waiting — living with symptoms in order to avoid the risks of more invasive treatment — is also often a reasonable alternative.

Physicians have different opinions about the outcomes and different preferences for the risks and benefits for these treatments. In a given community, the per capita numbers and specialty distribution of local physicians as well as individual physicians'

own predilections affect the chances for undergoing a particular treatment. This uncertainty about the best choice of treatment, and the tendency for physicians to choose treatments according to their own preferences, rather than those of patients, has created a health care economy driven by supplier-induced demand.

Nine conditions--angina, arthritis of the hip and knee, silent gallstones, menopausal conditions affecting the uterus, peripheral vascular disease, back pain due to disc disease, atherosclerosis of the arteries of neck and an enlarged prostate-- account for well over half of the major surgery done in the United States. For each condition, there are other options, some of which are listed in Table One. But for most of these conditions, the relative risks and benefits of the existing panoply of treatments (or non-treatments) have not been adequately evaluated.

Communities served by the nation's most prestigious academic medical centers are not immune from the supplier-induced demand that follows from uncertainty about outcomes and entanglement of preferences. Residents of New Haven, for example, have twice the risk for cardiac bypass surgery as do Bostonians (whose clinicians favor non-surgical interventions more often); New Haven women have about twice the risk for hysterectomy; But for hip surgery and surgery on the arteries of the neck, the risks for surgery are much higher for residents of Boston than for New Havenites. For these conditions, New Haven clinicians prefer the more conservative medical management.

Similar patterns of treatment variation exist for the other conditions listed in Table One.

Medical admissions for conditions such as pneumonia, chronic congestive heart failure or low back pain exhibit a second, more costly, pattern of variation. For these conditions the important variation is not the form of treatment, but the place where treatment occurs - in the hospital or outside it.

In areas with fewer beds, these conditions are more often treated outside of the hospital. Residents of Boston use about 4.5 hospital beds per 1,000 residents, while the residents of New Haven use 2.9. Virtually all of the excess capacity" in acute sector beds in Boston is invested in the inpatient management of medical problems that in New Haven (and other low bedded areas) are treated in less costly settings. These supply-sensitive patterns of variation are extremely important in explaining overall differences in per capita investment in hospital resources and costs between hospital markets.

Outcomes Research

Outcomes research investigates the reasons for variation, clarifies the theoretical basis for choice of treatment, and estimates the chances for the outcomes that matter to patients. It is particularly applicable to conditions such as those listed in Table One.

My colleagues and I have investigated the choices facing men with one of these conditions, a common form of prostate disease called benign prostatic hyperplasia, or BPH. In the mid-1980s, when our study began, we found that in some parts of the state of Maine, the chances that a man would undergo a prostate operation by the time he reached age 85 was about 15 percent; in other communities, more than half the male residents underwent surgery by age 85. We asked a group of Maine urologists, some of whom lived in areas with low rates of surgery for BPH, others of whom lived in high rate communities, if they could explain these variations.

The surgeons differed in their assumptions about the nature of the underlying illness, as well as the benefits to be derived from a prostate operation. Some physicians believed that BPH usually progresses to a life-threatening obstruction of the bladder or kidney and that it is best to operate early in the course of the disease to prevent future bad outcomes, including premature death. Other surgeons were more optimistic about untreated BPH. They argued for the "quality of life" theory of surgery; they believed that the benefit of surgery for most men is its ability to reduce symptoms and improve the quality of life.

The unresolved conflict between the preventive and the quality of life theories reflected indeterminacy rooted in poor clinical science. Our work in the evaluative sciences is directed at reducing this uncertainty. In a clear-cut demonstration of how outcomes research works to reduce uncertainty for doctors and patients, the outcomes research we undertook in Maine showed that the preventive theory was incorrect. Early surgery appears to lead to a slight *decrease* in life expectancy, because for most men BPH does not progress to life-threatening obstruction, and surgery for BPH — like any surgery — carries with it certain risks, including the risk of death. If prostate surgery has a place, it is in accordance with the quality of life theory — the reduction of symptoms for men who are severely bothered by them and willing to assume the risks of surgery in the hope of relief of those symptoms.

Shared Decisionmaking

But the problem is more profound than the failure to understand the theoretical basis for clinical decisionmaking or to measure the outcomes that matter to patients. Most urologists who believed in the quality-of-life hypothesis also practiced within the delegated decisionmaking tradition. They understood that they bore a special responsibility as the patient's agent to interpret for him what he needed and to convince him, for reasons of his own best interest, to accept their prescription. Our research demonstrated the flaws in delegated decisionmaking. What patients want cannot be predicted. Even answers to questions about the severity of symptoms or impairment of quality of life did not predict what the individual wanted. When shared decisionmaking was substituted, we found that patients who by all such objective measures are similar, differ in their preferences for treatment. Indeed, as it turned out, when offered a choice, nearly 80% of men with severe symptoms chose watchful waiting. They preferred to live with their symptoms rather than undergo the risk of operation, at least initially.

Preferences for outcomes and aversions to risk cannot be intuited by physicians based on objective knowledge; *to know what patients want, physicians must ask them.* Decisionmaking must be shared.

When preferences are neglected or misunderstood, the value of medical care can actually be negative. For example, our studies predict that among any sixteen severely symptomatic men, only four will want surgery when they are asked. If surgery were prescribed to all sixteen on the basis of the delegated decision model — under the assumption that symptom relief rather than avoidance of complications is every man's preference — then most patients will receive care they do not want. For these patients, the expected value of surgery is actually *negative,* compared with the benefit they would have obtained from the watchful waiting option they would have chosen had they been given a choice of treatments.

Islands of Rationality

When conditions such as those in Table One are subjected to the rationalizing influences of outcomes research, and when patients are offered an active role in the choice of treatment through shared decisionmaking, the influences of a supplier-induced demand economy can be contained. Islands of rationality can be created where uncertainty is reduced and where demand is based on patient preferences. Such islands circumscribe a territory where answers are possible to the questions of ethics and economics raised by the variations phenomenon: what is the rate of service use (and resource use) when patients are informed about what is known and not known about the outcomes that matter to them, and they are free to choose among treatment options according to their own preferences, according to their attitudes toward the benefits and the risks?

When patients with BPH are fully informed about their treatment options and asked to participate in clinical decisions, they choose watchful waiting more often than they do when decision making follows the delegated model; choice of treatment is influenced by the degree to which patients are bothered by their symptoms and how much they fear impotence or other sexual complications. When shared

decisionmaking replaces the delegated decision model, the population-based rate of surgery declines. The trend toward conservative treatment choice is evident even in HMOs where the rates of surgery are already relatively low (and where patients face no cost barriers at the point of delivery). Our research indicates the serious possibility of significant negative returns on current patterns of resource deployment under the delegated decision model.

The Problem of Excess Capacity

As important as outcomes research and shared decisionmaking are for the reform of the ethical and scientific basis of clinical medicine, I do not want to raise false hopes that they provide a mechanism for regulating the overall capacity of the health care sector. New ideas and new technologies offer an almost limitless horizon of medical possibility. Sorting out what works and what patients want cannot keep up with the urge physicians feel to try to do something beneficial, no matter how weak the scientific basis of its efficacy may be. Much of what physicians do is not governed by explicit theory. As clinical problemsolvers, it is in the nature of physicians to deploy available resources close to the point of scarcity. This behavior is not the result of simple self-interest; it arises from physician's perceptions of their role as healers, their faith in technology and willingness to work to find solutions to the endless stream of problems their patients present.

Supply thus exercises an almost subliminal threshold effect on clinical judgment. The effect of the supply of beds on the clinical thresholds for hospitalizing patients offers a good example. As I have already stated, the supply of hospital resources varies remarkably among geographic areas. These different rates are unrelated to illness rates or to explicit theories about the numbers of beds required to treat most diseases. I have mentioned that in communities where more beds are available, they are allocated across a broad range of medical conditions; in low bedded areas, patients with these conditions are more often treated outside of the hospital.

It is quite possible that a higher per-capita rate of investment in the acute hospital sector care produces no net benefit over what is achieved with lower per capita rates. As the numbers of beds increase, more resources are invested in the care of the chronically ill as measured by the proportion admitted to the hospital and the frequency of re-admission. More is invested in the last year of life and in terminal care. The quality of death is effected. The residents living in communities with more hospital beds per capita experience a greater probability that when death occurs, it will occur in a hospital. This threshold effect on the place of death is a constant and near linear function of per capita bed use, ranging from about 30% of deaths occurring in hospitals in areas with low per capita bed supply areas to 60% in high per capita areas. This relationship among New England Hospital Service areas is illustrated in Exhibit One. But does this greater investment in resources result in better outcomes? The evidence is that it does not. Mortality rates are not lower in areas with greater numbers of hospital beds. If anything, the trend is in the other direction.

Why, indeed, should greater spending bring better results? Recall the contingencies that determine the capacity of the health care system. Hospital capacity is not based on explicit theories about what works in medicine. The optimal number of beds is unknown. The number actually built in a community or made available in an HMO has no theoretic or empirical basis. One looks in vain in medical texts to learn how many beds are needed for treating a population's burden of illness. The number of beds is the result of the way the hospital industry has been planned and regulated. Per capita rates are arbitrary, the product of imperatives of institutions, communities, managed care companies and regulators--not the needs of patients or dictates of medical science.

The number of physicians who are trained is governed by equally arbitrary policies, many of which were set in the 1960,s when there was a great concern about medical scarcity. The number of specialists trained is the product of administrative and political choices, not the numbers required to produce services that are known to work or that patients want. In the case of procedure-oriented specialties, supply is also well in excess of the number of practitioners required to produce the treatments that physicians agree are efficacious.* Yet in fee-for-service markets, all find employment.

The movement to capitation, however, may change this dynamic. The numbers of specialists available to the U.S. health care economy are also well in excess of the numbers that would find employment if the work force strategies of pre-paid group practices such as Kaiser Permanente were the norm (Exhibit Two). If managed care along the lines exemplified by these organizations becomes the dominant model, large numbers of specialists may face unemployment.

Policies of Reform

I want to urge that the Clinton Health Plan and any alternative proposals that come before the Congress be evaluated in terms of their programs for improving the scientific and ethical basis of clinical decisionmaking and their ability to set limits and deal with the problems of excess capacity.

Certain principles and guidelines that find their empirical justification in our work may help the Congress with this task.

Principles for Setting of Limits

The first concerns the general welfare of the public: *It is safe for patients and in the public interest to place global restrictions on growth.* Studies of the geographic variations in services in this country provide solid evidence that the capacity of the hospital industry and of the physician specialty work force are now well in excess of that required to provide services that are efficacious and that patients actually want. Most medical resources are allocated for treatments for which the theoretical basis for allocation is implicitly associated with the supply of resources and for which there is no empirical evidence that more is better. The nation can and should deal directly with the forces of inflationary growth in the health care sector--with the policies that determine the numbers and distribution of manpower, the size of the hospital industry, and the quantities of technology--without fear that such actions induce rationing of services that are known to be valuable. The excesses in capacity that exist in our health care system mean that the amount spent on health care can be directly limited. A health care system can be achieved that is in equilibrium with other sectors of the national economy without fear that valuable services must be rationed.

The second principle concerns the welfare of those who do not now have access to care because they lack insurance: *full entitlement of all Americans to health care can be instituted without increases in the proportion of GNP invested in health and without a loss of welfare to those now insured.* The fear that policies that extend health care entitlement to all citizens must necessarily exacerbate the cost crisis is unwarranted. The dynamics that determine the capacity and costs of health care markets are to a large extent independent of illness rates and the demands of patients. Physicians are unaware of the relative per capita quantities of resources invested in their markets; stated another way, they are unaware of the relative size of the population they are serving.

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* For example, when neurosurgeons enter medical markets, they almost invariably find that the available supply has already taken care of the demand for surgical management of brain tumors and head trauma, which are the procedures that all physicians agree are needed. Neurosurgeons must thus invest most of their efforts in treating conditions for which there are valid non-surgical options. As shown in Table One, these neurosurgeons keep busy doing back operations and carotid artery surgery. For these two conditions, the rates of surgery show large variations among neighboring communities. Our work suggests that the amount of neurosurgery now being supplied under the delegated decision model could well exceed the amount patients want when they choose according to their preferences.

The population of Boston could be increased 50% before the per capita level of investment in acute hospital care approximates that of New Haven. If this were done gradually, the thresholds for hospitalization would adjust toward the pattern seen in New Haven and it is unlikely that anyone in the medical care industry serving Bostonians (other than the accountants) would notice the difference. The major change in practice style would be less frequent admissions and re-admission of the chronically ill and less investment in terminal care.

Fewer than 15 percent of Americans are uninsured. An understanding of the epidemiology of medical care leads to the prediction that their entitlement would permit them to be absorbed into the health care system without loss of benefit to those now in and without any special increase in aggregate expenditures. The capacity to treat the uninsured is already there. The trick is to make it possible for the uninsured to compete on an equal basis for the attention of the health care system. In a steady state situation, the increases in costs for treating the uninsured will be offset by savings realized by reduced utilization among those now insured.

The third principle concerns the special interests of patients for whom expensive medical care is effective in a system characterized by excess capacity: *The resources required to meet unmet needs should be obtained by reallocation of excess capacity and not by rationing effective care.* From the point view of patients with costly diseases, the reallocation of excess capacity is a more humane way to meet unmet needs than is the deliberate withholding of expensive, effective care on the basis that the benefits are too costly. If the people of Oregon decide that total resources should be limited, then resources to meet unmet needs should be reallocated from excess capacity. Every state has its own Boston's and New Haven's. Rather than withholding specific treatments such as bone marrow transplants that are known to increase the expectation for life (and that patients are known to want), this principle would reallocate resources invested in the excess supply of hospital beds. Large quantities of resources are available for reallocation. If the utilization patterns of Boston became more like those of New Haven, 700 hospital beds in Boston would go unused, and, in 1982 dollars, $300 million would be available for reallocation to other medical needs.

The issue of the physician work force policy merits special Congressional attention. The federal government subsidies to graduate medical education have played an important role in stimulating the excess supply of specialists. Federal reimbursement policy through the Medicare program makes the situation worse. The current imbalance will not be easily redressed. It is not enough to simply reduce the numbers of specialists in training. New thinking is required. The excess capacity should be reallocated to meet unmet needs of which there are many. One of these is learning what works and how to produce care of high quality. Even with draconian cuts in the numbers, it would take years to reduce the supply of specialists towards the numbers per capita required by managed care organizations such as Kaiser Permamente (Exhibit Three). A dynamic policy will make it possible for physicians and other health care workers to allocate time to the complex tasks of managing quality in modern systems of care. The complexities of modern technology require a flexible, life-time approach to professional education. A dynamic policy will provide the opportunities for professional renewal, even the adoption of a new specialty, as part of a new public policy. The requirements for innovation suggest new roles for academic medical centers in fostering outcomes research, in promoting networks of quality and in providing lifetime learning.

Principles for Reform of the Doctor-Patient Relationship

Whatever the shape the Congress gives to the new American health care economy, I urge that the historic opportunity to promote reform of the scientific and ethical basis of clinical decisionmaking not be missed

The essential base for this reform is a strong, well-funded federal science policy for the evaluative clinical sciences. In an age of increasing technological complexity and choice, as well as increasing public sector involvement in health care, it is essential for public policy to support the needed improvements in the scientific and ethical basis of

clinical medicine made possible by the evaluative sciences. The overall goals should be to: (1) establish the evaluative sciences as "mainstream" disciplines in the nation's professional schools and as an expected competency for the practice of medicine, on equal footing with the clinical sciences; (2) establish the ethic of evaluation as a defining characteristic of the competent health care professional; and (3) provide the focus for empowering the health professions to take charge of the multiple tasks required to assure quality, reduce supplier- induced demand and promote lifetime learning.

It is also essential that federal oversight be dedicated to promoting reform of the doctor-patient relationship. State health plans, Health Alliances and Accountable Health Plans should each be evaluated in terms of how well they set in motion the processes to meet the following guiding principles:

1. Patients should be fully informed about what is known and not known about the outcomes of the relevant treatment options;
2. Patient preferences should determine the choice of interventions among available options;
3. The quality of care should be continuously monitored and improved; and
4. The outcomes of new as well as conventional treatment theories should be continuously evaluated and re-evaluated.

Table One. Common Conditions Which Are Treated In More Than One Way

Condition	Major Treatment Controversies
Noncancerous condition of the uterus	Surgery (by type) vs. hormone treatment vs. drugs vs. watchful waiting
Angina pectoris	Bypass surgery vs. angioplasty vs. drugs
Gallstones	Surgery vs. stone crushing vs. medical management vs. watchful waiting
Peripheral vascular disease	Bypass surgery vs. angioplasty vs. medical management
Cataracts	Lens extraction (by type) vs. watchful waiting
Arthritis of hip and knee	Surgery (by type) vs. medical management
Prostatism (BPH--benign prostatic hyperplasia)	Surgery (by type) vs. balloon dilation vs. drugs vs. microwave diathermy vs. watchful waiting
Herniated disc	Surgery (by type) vs. various medical management strategies
Atherosclerosis of carotid artery with threat of stroke	Carotid endarterectomy vs. aspirin

Exhibit One.

Shows the relationship between the level of investment in hospital care measured in patient days of care per 1,000 Medicare enrollees (horizontal access) and the proportion of Medicare deaths that occur while the patient is hospitalized rather than at home, in a nursing home, clinic or hospice. Each dot represents the experience of one New England Hospital Service area. As hospital capacity increases, the intensity of inpatient investment in terminal care increases. The investment does not seem to pay off in terms of an overall reduction in mortality among Medicare enrollees.

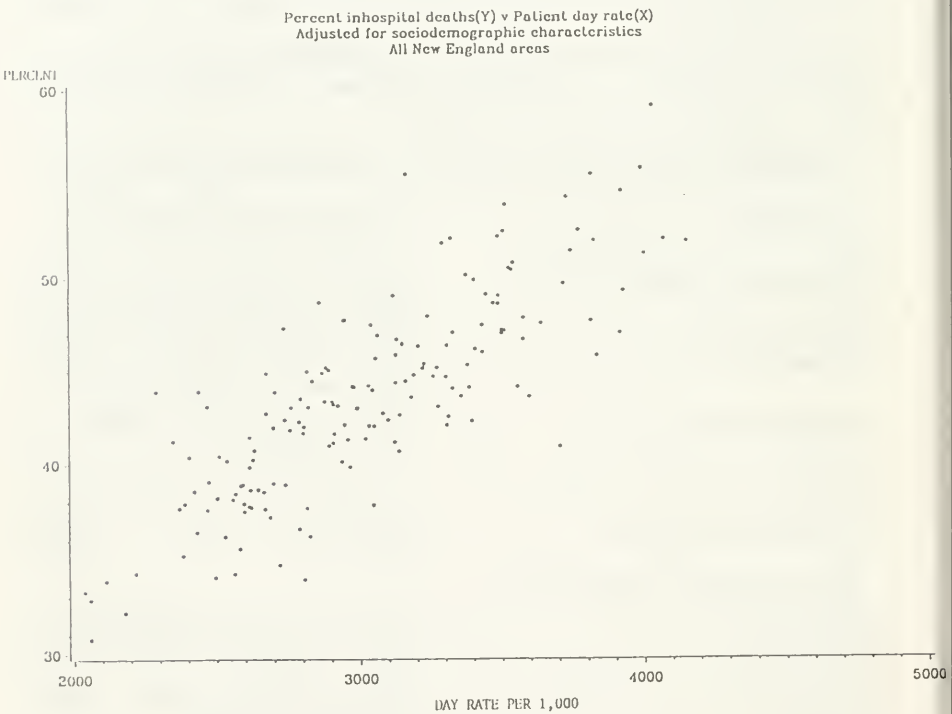


Exhibit Two.

Staff model HMOs such as Kaiser Permanente or Group Health Cooperative of Puget Sound provide the only examples of population-based work force planning in the United States. These HMOs use a population-based formula for hiring physicians which is remarkably similar from one HMO to another. The numbers of specialists employed by these managed care organizations is remarkably different than the numbers available in the private sector. The figure gives the ratio of the per capita number of clinically active physicians in the US compared to the per capita numbers hired by staff model HMOs. For example, the number of general surgeons available to the private sector is more than twice the number that would be hired if HMO work force policies determined national employment practices; the number of radiologists is fifty percent greater.

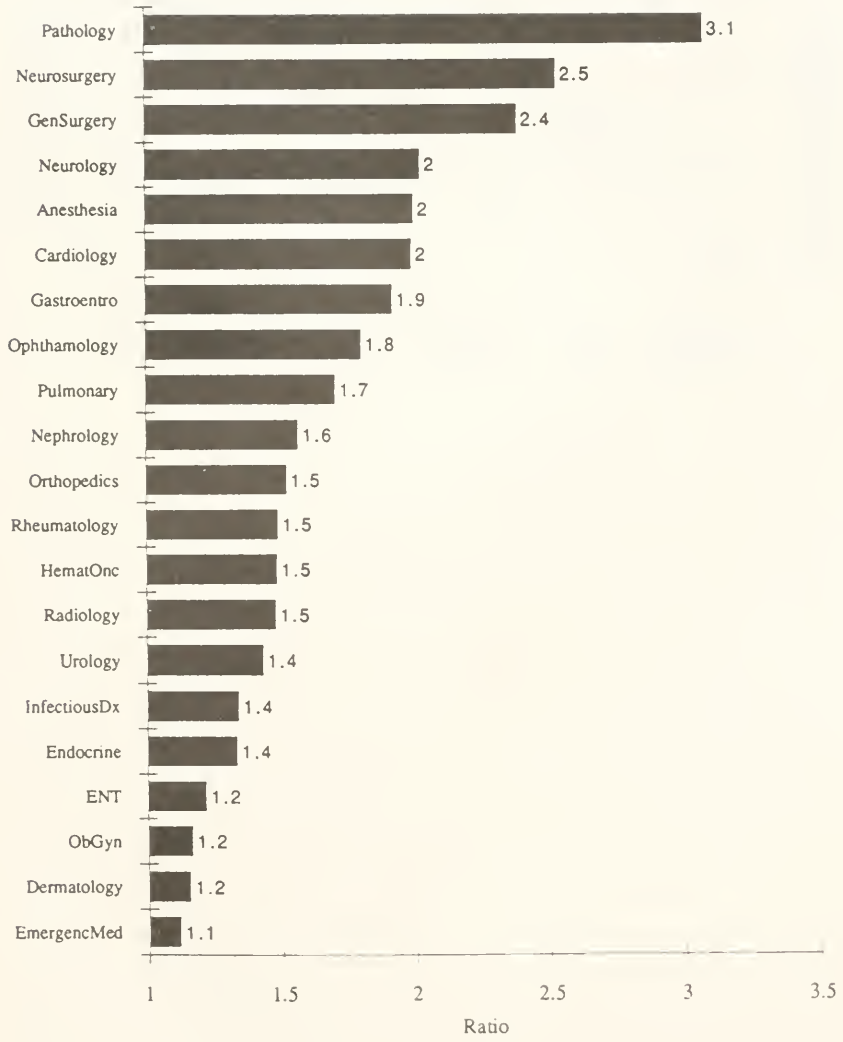
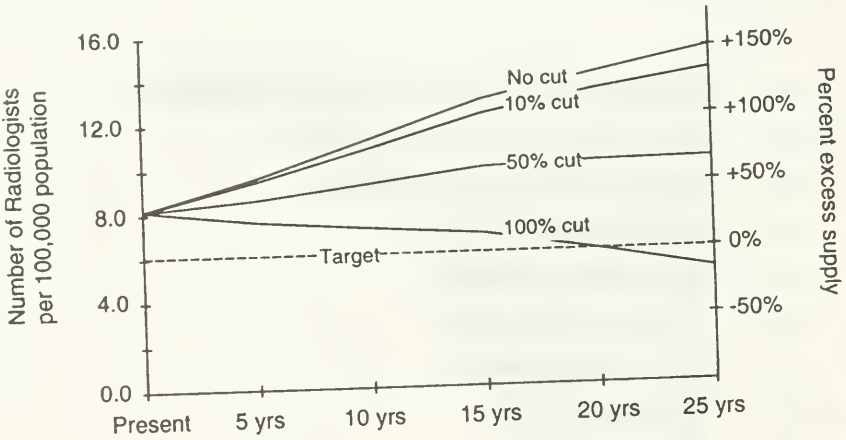


Exhibit Three.

One of the great policy issues facing the nation is what to do about the excess supply of specialists. It takes years to bring the supply into equilibrium with the numbers employed by HMOs. The exhibit shows the effect of reducing residencies on the supply of radiologists. Even under the strategy of eliminating all residency training, it would take more than 17 years to achieve the level that would find employment in HMO's. Other options for dealing with excess specialists are needed.



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PREPARED STATEMENT OF MERRILL MATTHEWS, JR.

There is no mystery as to why health care spending is out of control. A primary reason is that most of the time when patients enter the medical marketplace they are spending someone else's money rather than their own. Economic studies — as well as common sense — confirm that we are less likely to be prudent shoppers if we believe someone else is paying the bill. All economists and most health policy analysts recognize this crucial fact. Nevertheless, most health care reform proposals — including the President's — attempt to increase the role of third-party payers rather than diminish it. Because reformers know that increasing third-party payment will only increase spending, they want to hire a manager or government employee to look over the shoulders of the physicians and the patients to ensure no one is consuming too much medical care. Such proposals go in precisely the wrong direction, and they will never reduce health care spending with out significant rationing — which the American people will never stand for.

As an alternative, why not give patients, rather than insurers and bureaucrats, more control over their health care dollars?

Last year, 150 members of Congress thought it would be better to empower patients rather than bureaucrats and cosponsored one of 12 different bills designed to create Medical Savings Accounts (MSAs).[1] Also called Medisave Accounts and Medical IRAs, Medical Savings Accounts are attracting growing support again this year, as new MSA bills are being fashioned in the current legislative session.

The advocates of MSAs span party lines and ideological divisions. They include Democrats and Republicans, liberals and conservatives. Medical Savings Accounts also have widespread support outside the Washington Beltway. The concept has been endorsed by such diverse groups as the American Medical Association, the American Farm Bureau, the National Association of Health Underwriters and the National Association for the Self-Employed.

Why have so many people, representing such diverse points of view, decided that Medical Savings Accounts are an essential element of health care reform? Because MSAs are better than any alternative in attempting to reach five important goals: (l) controlling health care' costs, (2) maintaining the quality of health care, (3) getting more Americans covered by private health insurance, (4) making the market for medical care more competitive and (5) reforming Medicare, Medicaid and other government health care programs.

Under the current system, 250 million Americans find it in their self-interest to take actions that contribute to our nation's health care crisis. With Medical Savings Accounts, individual patients would become part of the solution instead of remaining part of the problem. Let's see how.

ESTABLISHING MEDICAL SAVINGS ACCOUNTS

In one sense, the establishment of Medical Savings Accounts for employees would represent only a small change in the tax law governing employer-provided health insurance. Yet this small change would give individuals an opportunity to take control of a substantial portion of their own health care dollars. If individuals took full advantage of this opportunity, there would be a major transfer of money and power from third-party payer bureaucracies (employers, insurance companies and government) to individual patients. The result would be a radical transformation of the medical marketplace.

How Medical Savings Accounts Work. Medical Savings Accounts would be tax-free personal accounts used to pay medical bills not covered by insurance. Regular

[1] The general case for Medical Savings Accounts is presented in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, Dc: Cato Institute, 1992), p. 76. A shorter version of the argument may he found in John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

deposits could be made by individuals or their employers, but they would be the property of individuals. Money could be withdrawn without penalty only to pay medical expenses and health insurance. Money not spent would grow tax free and could be used for medical expenses after retirement, rolled over into an IRA or private pension plan, or would become part of the owner's estate at death.[2] MSAs would ensure that people would have money to pay small medical expenses, including expenses for preventive care, and to pay insurance premiums if they change jobs or become unemployed.

The Relationship Between Medical Savings Accounts and Health Insurance. Medical Savings Accounts represent a new way of paying for health care. Under traditional health insurance, people make monthly premium payments to an insurer (such as Blue Cross) and the insurer pays medical bills as they are incurred. Under the new system, people could confine health insurance to catastrophic coverage with deductibles of, say, $2,500 to $3,000, reduce their monthly insurance premium payments and make deposits to a Medical Savings Account instead. Under this arrangement, insurance would be used to pay for expensive treatments that occur infrequently, while MSA funds would be used to pay small bills covering routine services. MSA funds not spent would build up over time. Thus after a few years, most families would have MSA balances equal to, or greater than, the deductible on their catastrophic policy.

Why Government Action Is Needed. Under current law, every dollar of health insurance premium paid by an employer escapes, say, a 28 percent income tax, a 15.3 percent Social Security (FICA) tax and a 4, 5 or 6 percent state and local income tax, depending on where the employee lives. Thus government is effectively paying up to half the premium — a generous subsidy that encourages employees to overinsure.[3] At the same time, the federal government discourages individual self-insurance by taxing income that individuals try to save in order to pay their own future medical expenses. By subsidizing third-party insurance and penalizing self-insurance, federal tax law prevents employees and their employers from taking advantage of the opportunities that a Medical Savings Account option would create.

HOW MEDICAL SAVINGS ACCOUNTS CAN HELP CONTROL RISING HEALTH CARE SPENDING

One of the most serious health policy problems we face is rising health care spending.[4] Over the past decade, health care expenditures grew about twice as fast as our gross national product. If that trend were to continue — which it cannot — we would be spending 100 percent of our income on health care by the middle of the next century.[5]

Why Third-Party Payment of Medical Bills is the Cause of the Problem. As mentioned earlier, a primary reason why health care spending is out of control is that

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[2] Some have suggested more liberal options for using the funds, including those that now apply to 401 (k) pension plans, which permit use when certain disabilities arise or for education expenses under conditions of financial hardship. Others have suggested that once the balance exceeds a certain level, account holders should he able to withdraw funds tax free — or at least without a penalty. Other proposals would restrict the use of MSA funds, for example, by limiting the amount that could accumulate in an MSA or by taxing the interest income.

[3] Given a fixed amount of total compensation, employers will tend to be indifferent about its makeup, i.e., how much is paid in wages vs. fringe benefits. The tax law, however, encourages employees to choose too much non-taxed health insurance and too little taxable wages. See Goodman and Musgrave, *Patient Power,* chapter 9.

[4] This problem is often described as the problem of rising costs. However, it is not clear that costs in the sense of average cost per treatment are rising. More importantly, the term "costs" encourages people to focus solely on the supply side of the market, when the fundamental source of the problem is on the demand side. See the discussion in Gary Robbins, Aldona Robbins and John C. Goodman, "How Our Health Care System Works," National Center for Policy Analysis, NCPA Policy Report No. 177, February 1993.

[5] See Goodman and Musgrave, *Patient Power*, p. 76.

most of the time when we enter the medical marketplace as patients we are spending someone else's money rather than our own. Although polls show that most people fear they will not be able to pay their medical bills from their own resources, the reality is that most of us pay for only a small portion of the medical care we receive. On the average:[6]

- Every time we spend $1 in a hospital, we pay only 5 cents out-of-pocket, and 95 cents is paid by a third party (employer, insurance company or government).
- Every time we spend $1 on physicians' fees, we pay less than 17 cents out-of-pocket.
- For the health care system as a whole, every time we consume $1 in services, we pay only 21 cents out-of-pocket.

Moreover, the explosion in health care spending over the past three decades parallels the rapid expansion of third-party payment of medical bills. The patient's share of the bill has declined from 48 percent in 1960 to 21 percent today.

The Wastefulness of Third-Party Insurance. A great deal of the waste in our health care system is caused by people who have too much insurance. And one way in which people overinsure is through low deductibles or, in some cases, complete first dollar coverage. Low-deductible health insurance is usually wasteful for three reasons. First, low-deductible insurance encourages people to consume services they do not really need. That ultimately causes costs and premiums to rise for all policyholders. Second, low-deductible insurance discourages people from seeking low prices for the services they do consume. Third, using insurance to pay small medical bills leads to wasteful administrative expenses. For example, a $25 physician's fee can easily become $50 in total costs after an insurer monitors and processes the claim — thus doubling the cost of medical care.[7]

The Necessity of Choosing Between Health Care and Other Uses of Money. Most proposals to control health care costs turn out to be proposals to create a one-time reduction in health care spending. These proposals focus on ways of eliminating waste and improving efficiency. Yet even if they were successful, they would have no effect on the long-term trend. The long-run problem exists because people are rarely asked to choose between health care and other uses of money. As a consequence, they have an incentive to consume health care services as though they were costless. And, as long as people act on that incentive, health care spending will continue to soar.

How Medical Savings Accounts Would Help Control Spending. Given that someone must choose between health care and other uses of money, who will that someone be? Medical Savings Accounts give patients themselves the opportunity to make those decisions, after consulting with their physicians. Even though people would undoubtedly make mistakes, they would have the incentive to make good decisions rather than bad ones. And studies of actual patient behavior give us every reason to believe that empowering patients would lead to beneficial results. For example, Rand Corporation studies imply that families with a $2,500 deductible consume 30 percent less health care than families with no deductible — with no adverse effects on health.[8]

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[6] These estimates are based on National Health Accounts data for personal health expenditures adjusted for tax subsidies and include the administrative costs for private health insurance. See Robbins, Robbins and Goodman, "How Our Health Care System Works."

[7] See the discussion in Goodman and Musgrave, "Controlling Health Care Costs With Medical Savings Accounts."

[8] The Rand Corporation, in a study conducted from 1974 to 1982, found that people who had access to free care spent about so percent more than those who had to pay 95 percent of the bills out-of-pocket up to a maximum of $1,000. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today. See Robert Brook et al., *The Effect of Coinsurance on the Health ofAdults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review,* June 1987. The Rand study found no significant differences in the health status of people who had high and low deductibles. The one exception was vision care. See Joseph

HOW MEDICAL SAVING ACCOUNTS CAN HELP MAINTAIN THE QUALITY OF CARE

In an effort to stem the tide of rising costs, third-party-payer bureaucracies increasingly are imposing arbitrary rules and regulations on the providers of health care. Whereas it was once thought to be unethical for third-party payers to interfere with the doctor-patient relationship, today some of these bureaucracies are literally trying to dictate the practice of medicine. Although this trend is often defended on the grounds that it makes medicine more scientific, in practice it may substitute "cookbook" medicine for the judgment of trained professionals. With increasing frequency, physicians who want to admit a patient into a hospital or order a routine diagnostic test find that they must get telephone permission in order to do so. Permission is often given or denied, not by a professional, but by a clerk looking up symptoms in a manual.

How Third-Party Payers are Replacing Patients as the Real Customers of Providers. Because health insurance is the primary method of payment for the medical care Americans consume, in a very real sense it is the insurer rather than the patient who is the customer of medical providers. For example, when Medicare patients interact with the health care system, *what* procedures are performed — and *whether* a procedure is performed — increasingly is determined more by Medicare's reimbursement rules than by the patient's preferences or the physician's experience and judgment. Although this phenomenon is more evident in government health care programs (Medicare and Medicaid), private insurers and large companies are increasingly copying the methods of government.

As a result, we are evolving not into a two-tier system of medical care, but into multi-tier system — in which the quality of health care a patient receives is increasingly determined by the third-party payer. The way medical care is now being delivered, Medicare patients may get one type of care, Medicaid patients another and Blue Cross patients yet a third.

How Medical Savings Accounts Could Make a Difference. The primary reason why third-party payers are interfering with the practice of medicine — denying people access to new drugs and new technologies — is that under the current system third-party payers are paying most of the bills. Since patients are encouraged to perceive health care as free at the time when they receive it, third-party payers must exercise the responsibility for choosing between health care and other uses of money. Third-party payers cannot be blamed for making these decisions. Given that people entrust their health care dollars to these institutions, they would be irresponsible if they didn't attempt to eliminate "unnecessary" procedures and substitute cheaper drugs for more costly ones when they judge the risk to be acceptable. The problem, of course, is that third-party-payer preferences toward risk may be very different from the preferences of patients. In fact, it could not be otherwise, since there are wide variations in the willingness to bear additional costs in order to avoid risks among patients themselves.

Medical Savings Accounts would give patients the opportunity to satisfy their own preferences. Rather than give all the money and power to a bureaucracy, MSA holders would control a substantial fraction of their own health care dollars and make important decisions for themselves. As a result, medical providers would begin to regard patients as their customers rather than employers, insurance companies and government. And if patients retained both the money and power to make decisions, they would receive a great deal of information that today they are denied.

Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medic ine,* Vol. 305, No. 25, December 17, 1981, pp. 1501-07; and Robert Brook et al, "Iooes Free Care Improve Adults HealthT *New England Journal of Medicine,* Vol. 309, No. 23, December 8, 1983, pp. 1426-34.

HOW MEDICAL SAVINGS ACCOUNTS WOULD INCREASE THE NUMBER OF PEOPLE WITH PRIVATE HEALTH INSURANCE

Like being unemployed, being uninsured is an experience that most Americans will probably endure at some time in their lives. But the experience is likely to be short lived. Just as there are very few long-term unemployed, there are very few long-term uninsured.[9]

- Of the 37 million Americans who are uninsured this month, more than 50 percent will be insured 5 months from now.
- More than 70 percent will be insured within one year.
- Only 15 percent of the uninsured population will remain continuously uninsured for the next two years.

Moreover, contrary to widespread impressions, most of the 37 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age and in the healthiest population age groups.[10] They have below-average incomes and few assets. As a result, they tend to be very sensitive to premium prices. Moreover, the primary reason why most of them are uninsured is that they have judged the price too high relative to the benefits. Less than I percent of the population is both uninsured and uninsurable.[11]

How Government Policy Causes People to be Uninsured. Government policy adds to the number of uninsured in three ways. First, federal tax policy encourages an employer-based system in a very mobile labor market. When people leave a job, they eventually lose their health insurance coverage.[12] Second, government tax policy encourages people to remain uninsured while they are between jobs in which they will have employer-provided coverage. Currently, government "spends" more than $90 billion a year in tax subsidies for health care — mainly by allowing employer-provided health insurance to be excluded from the taxable income of employees. As a result, some employees receive tax subsidies worth 50 cents for every $1 of health insurance. Yet those who must purchase their own health insurance get no help from government and often pay twice as much aftertax for the same coverage. Those discriminated against include the self-employed, the unemployed and employees of small businesses that do not provide health insurance.[13]

Finally, state regulations are increasing the cost of private health insurance and pricing millions of people out of the market. For example, state-mandated health insurance benefits laws tell insurers that in order to sell health insurance in a state, they must cover diseases ranging from mental illness to alcoholism and drug abuse, services ranging from acupuncture to in vitro fertilization, providers ranging from chiropractors to naturopaths. These mandates cover everything form the serious to the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and deposits to a sperm

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[9] Katherine Swartz and Timothy D. McBride, "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry 27,* Fall 1990.

[10] Jill D. Foley, Uninsured in the United States: The Nonelderly Population Without Health Insurance (Washington, DC: Employee Benefits Research Institute, April 1991), p. 16.

[11] Karen M. Beauregard, "Persons Denied Private Health Insurance Due to Poor Health," Agency for Health Care Policy and Research, Public Health Service, AHCPR Report No, 92-0016, December 1991.

[12] See the discussion in Stuart Butler and Edmund Haislmaier, eds., *A National Health System for America,* rev. ed. (Washington: Heritage Foundation, 1989).

[13] See Goodman and Musgrave, *Patient Power.* Chapter 9. The problem is exacerbated by the fact that the tax subsidies tend to go to people who least need help from government. Families in the top 20 percent of the income distribution get almost six times as much benefit from these subsidies, on the average, as families in the bottom fifth. See C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference, "American Health Policy" (Washington, October 34, 1991).

bank in Massachusetts.[14]

By one estimate, one out of every four uninsured people has been priced out of the market by state-mandated benefits laws.[15] In addition to mandates, private insurance is burdened by premium taxes, risk pool assessments and other regulations. Ironically, most large corporations are exempt from these regulations because they self-insure.[16] As a result, the full weight of these regulations falls on the most defenseless part of the market: the self-employed, the unemployed and the employees of small businesses.

How Medical Savings Accounts Can Be Part of the Solution. One way to undo the harm caused by government policies is to change the policies that cause the harm. Thus we could end the practice of subsidizing an employer-based health insurance system, extend tax relief to those who purchase their own health insurance and repeal onerous state regulations. Even if these changes are not made, however, Medical Savings Accounts can make a big difference.

With Medical Savings Accounts, people would have a store of savings with which to continue their premium (COBRA) payments during periods of unemployment[17] or to purchase a new policy. And, because MSA contributions would be tax subsidized, the payment of insurance premiums with MSA funds would also be tax subsidized. Moreover, because MSAs would allow people to take advantage of high-deductible health insurance, they also would allow people to escape the most costly burdens of state- mandated health insurance benefits. Mandates have much less impact on the price of a $3,000-deductible policy than they do on the price of a $250-deductible policy.

HOW MEDICAL SAVINGS ACCOUNTS WOULD HELP MAKE THE MEDICAL MARKETPLACE MORE COMPETITIVE

In most American cities, patients cannot find out a hospital's charge for a procedure prior to treatment. When they get the bill, about 90 percent of the items listed on a hospital bill are unreadable. In only a handful of cases can patients both recognize what service was rendered and judge whether the charge is reasonable. Patients who try to find out about prices prior to admission face another surprise. A single hospital can have as many as 12,000 different line item prices. For potential patients of the 50 hospitals in the Chicago area, there are as many as 600,000 prices to compare. To make matters worse, different hospitals frequently use different accounting systems. As a result, the definition of a service may differ from hospital to hospital.[18]

Hospital Bills for Patients Who Pay Their Own Way. There is overwhelming evidence that hospital prices are the result of a market dominated by bureaucratic institutions rather than any intrinsic feature of the services rendered.

Take cosmetic surgery, for example. In general, cosmetic surgery is not covered by any private or public health insurance policy. Yet, in every major city there is a thriving market for it. Patients pay with their own money and, despite the fact that many separate fees are involved (payments to the physician, nurse, anesthetist or anesthesiologist, hospital, etc.), patients are almost always given a fixed price in advance — covering all medical services and all hospital charges.[19] Patients also have choices

[14] John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

[15] Ibid.

[16] This is made possible under the provisions of the Employee Retirement Income Security Act, 1974.

[17] Under the provisions of the Consolidated Budget Reconciliation Act (COBRA), employees are entifled to continue coverage for up to 18 months after they leave an employer.

[18] See Goodman and Musgrave, *Patient Power,* pp. 52-58.

[19] To our knowledge, no one has studied the market for cosmetic surgery. That is unfortunate because most of what employers and insurers have unsuccessfully tried to accomplish for other types of surgery over the past decade has occurred naturally with few problems and little fanfare in the market for cosmetic surgery.

about the level of service (for example, surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Overall, patients probably have more information about quality in cosmetic surgery than in any other area of surgical practice.

The characteristics of the market for cosmetic surgery also are evident in other medical markets in which patients are paying with their own funds. For example, private-sector hospitals in Britain frequently quote package prices for routine surgical procedures. U.S. hospitals often quote package prices to Canadians who are willing to come to this country to get care that is being rationed in Canada. In many cities, Humana hospitals now advertise package prices for well-baby delivery to prospective parents. And although they rarely discuss it, many hospitals have special package prices and discount rates for uninsured patients who pay their own bills.

Why Medical Savings Accounts Would Make a Difference. Most patients already know that physicians will usually give them a better deal if they pay their own bill — especially at the time of treatment. Increasingly, the same is true of hospitals. By empowering patients and making patient payment a dominant force in the medical marketplace, the market will become increasingly competitive.

HOW MEDICAL SAVINGS ACCOUNTS CAN HELP REFORM GOVERNMENT HEALTH CARE PROGRAMS

Most discussions of the problem of rising health care spending in the United States imply that the problem has been created by the private sector. Many who adopt this view are also inclined to believe that successful health care reform can disregard government programs such as Medicare (for the elderly) and Medicaid (for the poor). In fact, the primary source of the problem is government itself, not the private sector, and the primary way in which government is creating the problem is through direct spending programs.

The Size of the Public Sector. When federal tax subsidies for health insurance are combined with direct spending, government at all levels (federal, state and local) spends more than half of all health care dollars. Overall:[20]

- Direct government spending has increased from 24 percent of all health care spending in 1960 to 42 percent in 1990.
- When tax subsidies for health insurance are included, the government's share of health care spending has increased from 34 percent in 1960 to 53 percent today.

Using Medical Savings Accounts to Control Costs in Government Programs. Since the primary reason why health care costs are rising is government subsidy and since 80 percent of spending generated by government is through direct spending programs — primarily Medicare and Medicaid — it follows that if health care spending is to be brought under control, Medicare and Medicaid must be reformed.

Medisave accounts could change incentives, and therefore behavior, in these programs. One way to change Medicare, for example, is to have government give each Medicare beneficiary catastrophic coverage with a deductible equal to, say, 10, 20 or 30 percent of their income. In return, the beneficiaries could deposit their current Medicare Part B premium, medigap insurance premiums and out-of-pocket money into a Medical Savings Account.[21]

CONCLUSION

Health care costs in the United States could be reduced substantially if people relied on third-party insurance for catastrophic expenses only and paid small medical bills by drawing on individual Medical Savings Accounts. This reform would preserve the strengths of the current system while giving patients the economic incentive to be prudent consumers in the health care marketplace. With Medical Savings Accounts, bureaucrats and third-party payers would be removed from the vast majority of health care decisions, putting patients, in consultation with their physicians, back in control. Neither government nor third-party payers can effectively control health care costs. But 250 million Americans, pursuing their own interests as patient/consumers, can make a huge difference.

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[20] Source: NCPA/Fiscal Associates Health Care Model.

[21] See Milton Friedman, "Input and Output in Medical Care," Hoover Institution, 1992.

PREPARED STATEMENT OF ALLEN FEEZOR

I am Allen Feezor. For nine years, I have served as North Carolina's Chief Deputy Commissioner of Insurance, and Commissioner Jim Long. As an official who is elected statewide, Commissioner Long, like the members of this committee, has great concern about the twin problems of accessibility and affordability of health coverage and, accordingly, has committed substantial departmental resources to identifying meaningful health care reform initiatives. One element of these efforts was our department's staffing in the development of the National Association of Insurance Commissioners' "market reform proposal." This reform actually included two model acts--one that dealt with rating (and underwriting reform) and the other dealt with the guaranteed availability of products. In the past 30 months, approximately 40 states have enacted some form of rating reform and nearly two dozen have enacted the guaranteed availability.

In the course of this effort, we have become even more painfully aware of the evolution of; and wide variations in, rating practices that the payer industry has come to employ. Drawing on this experience, as well as my prior ten years within the private payer industry, I would like to share a few observations that may have some import for Congress as it begins to evaluate the appropriate responses and/or modifications to the President's proposal.

It should be noted that I have been asked to testify as an individual. Accordingly, my remarks should be viewed not those of the NAIC, Commissioner Long, or the North Carolina Department of Insurance.

HISTORICAL PERSPECTIVE

Others have set forth what they viewed as the historical evolution of rating practices within the health insurance field. As a quick layman's guide, I recommend Chapter III of the Institute for Health Policy Solutions' *Health Care Financing Reform to Cover The Uninsured.* Accordingly, I will highlight what I consider to be some of the more salient (or perhaps overlooked) aspects.

The Blues are generally credited as being the first predominate and most influential payers in most states. Because of this, and their limited markets (mostly within a single state), the earliest rating schemes and territories tended to be literally the state or communities in which the (Blue) Plans operated. States still exercise a great deal of control over many of the contributing factors that cause variations in rates (education and licensing of professionals, health care resource allocation decisions, public and private benefits and reimbursement rates, etc.). Yet, clearly the emergence, if not the dominance, of large national commercial payers and their almost unlimited ability to process data and group individuals, providers, and benefits in an infinite number of ways, is challenging this reliance on the state as a rating territory. As discussed later, a wide variety of new rating techniques and factors are being employed along with a nearly infinite number of risk selection techniques.

Commercial carriers, with their targeted marketing efforts are generally credited with the first segmentation of the (community) risk pool. Commercial insurers used age and gender to set employer rates. Later, other demographic characteristics were added. However, it was government action that perhaps provided the two greatest segmentations of the market: the enactment of Medicare and the passage of ERISA. Medicare's segmentation of the over-65 population had a positive effect on the rest of the community—although its greatest impact was no doubt on the availability and affordability of coverage for senior citizens.

The passage of ERISA in 1974—among other things, made it very clear that states could not preclude what many larger employers had sought to do—to remove themselves from broader risk pools, initially by experience rating and later by "self-insuring" or self-funding. The growth toward self-funding has been rapid. Prior to experience rating, many insurers "segmented" the experience of their groups by size (1,000+ life; 500-1,000; 100-500; and below 100). Most state regulation tended to focus on overall rate adequacy, and fairness for the smaller group and non-group rates. Currently, by

most estimates, between 45% and 60% of the privately sponsored health coverage is "self-funded", and hence, exempt from any state review of rates, rating, and underwriting for these plans. Without any doubt, the single greatest segmentation of the private employer-based market has been the self-funded movement.

It should be noted that the decision to "self-fund" is prompted by more factors than simply seeking to establish one's own rate by pooling one's risks internally. Among other considerations are: elimination of statutory reserves or contingency fees charged by insurers; cash flow management more consistent with other capital needs; greater uniformity and latitude in benefit design; avoidance of state premium taxes; and avoidance of benefit mandates.

While experience rating has been around for years, it was the hyper-inflation in health care of the late '70s and early '80s that accelerated the evolution of experience rating (and self-funding). This was sought by employers and fostered by insurers who began to employ experience rating as a competitive tool. Underwriting (risk selection) also began to take on new import in this period.

Initially, self-funding was limited by practice to 1,000-and-over groups. Ultimately, it has evolved (wisely or not) to apply to groups of 100 lives, and with the use of stop loss arrangements, down to fewer than 50 life groups. In the late '70s, efforts by small employers to remove themselves from insurer pools and to avail themselves to the perceived advantages of experience rating and self-funding, produced rather spectacular failures of numerous Multiple Employer Trusts (METs) and Multiple Employer Welfare Arrangements (MEWAs). This led to the enactment of the Erlenborn Amendments to ERISA in 1982 in an effort to assure appropriate regulation over such entities. Based on the results of a recent GAO report that noted nearly 400,000 U.S. citizens had lost their coverage (and premiums) in a 30-month period of time, it still appears that more needs to be done in this area.

The problems associated with the evolution of rating practices and the disaggregation of insurance pools manifested themselves in the late '80s. For a brief period subsequent to HCFA's introduction of DRG-based reimbursement, health care inflation slowed markedly. When health care costs took off again, it caught a lot of the insurance industry by surprise. This (re)inflation occurred sequentially to the casualty industry's greatest liability insurance crisis of the century. Much of the health insurance industry's reaction to its re-escalation of health costs mimicked the reactions of its P&C brethren to its mid '80s crisis: withdrawal of carriers; mid-term cancellations; dramatic premium increases; and an acceleration of the severity of underwriting and rating practices employed to profile, and more accurately, avoid risks. It was the small employer market which suffered the blunt of these disruptive practices. Unfortunately, by their own relatively thin profit margins, compounded by a recessionary economy in the late '80s, these employers were not able to absorb these changes. This led to a loud call for insurance reform.

TODAY'S RATING METHODS

Experience rating or rate modifications to pooled or community rates have existed for years. What we discovered was that the increasing use of experience rating had shrunk the remaining pools of risks. Further, that the rating techniques being employed by carriers moved the small employer market dangerously close to a self-funded or pure experience rated market in which each employer bears its own risk. Listed below are some of the more prevalent rating factors used in the rating and pricing of coverage. The list is by no means exhaustive, and indeed, there are no standard ways. Rather, rating techniques are limited only by the sophistication of data, creativity of those doing the rating, the philosophy or goals of the carrier, and now some state rating limits.

Benefit design is perhaps the most obvious rating variable. Currently, many purchasers have difficulty in comparing the value of competing products because of minute, but actuarially significant, deviations in benefits or policy terminology. Many health reform proposals suggest that this variable be controlled by standardizing the benefit plan available to each citizen.

Family size or composition is frequently rated differently by different insurers. While generally calculated around 2.5 times the cost for the individual, some insurers have established rates for single individuals and family; others have a category for a single insured with a single dependent; still others use a multiple of the number of members in the family, etc. Larger employers often determine the rates they want to charge for family coverage which generally requires employer premium sharing.

Size of Group is an increasingly significant factor in the rating of smaller groups. As previous CRS research has shown, there are differing "loading" factors for group size in several categories: administrative expense; marketing costs; credit risk; general risks; and the groups bargaining prowess. Some rates may even vary depending upon the percentage of the eligibles who participate and/or employer contribution.

Sales or Distribution Systems, used by the carrier may vary the rates charged. Insurers may use differing marketing and enrollment methods (captive sales vs. agent; direct writing; use of a TPA or an association, etc.).

Geographic Location is widely used to reflect differences in costs in different locales. A 1991 Milliman and Robertson survey showed a variation by as much as two-fold in premiums quoted among major metropolitan areas. Differences in urban vs. rural may provide large variances (in the range of 1.5 and 2 to 1) within a state. The ability to segment data down to a specific zip code level has added a whole new definition to the term "community" and may not bode well for smaller communities with particularly acute or unique health problems (like AIDs).

Gender and Age are perhaps among the oldest and most consistent rating factors employed. Age (within the same gender) may produce a rate factor of 4 to 1. The gender factor may run 2 to 1. Compounded they may run 8 to 1 or more. Type of Business/Industry has been used as a factor to allow increased charges relative to higher credit or administrative costs that tend to be incurred with certain employer groups (due to high turnover or slow payment). It also has been used to reflect higher claims costs of some groups due to either a perceived more hazardous work environment, or an employer group's proclivity for higher claims expenses. In the late `80s, prior to states adopting reforms, it was not unusual to find many businesses (florists, bars and restaurants, dentists, mining operations, law firms) appearing on an insurer's "black list" (i.e., as those they would not cover at all).

Health Status, anticipated or demonstrated, has become perhaps the most critical—and pernicious of rating techniques. Increasingly, insurers have demanded more information upon application in an effort to assess risks. This produced a rise in the use of underwriting techniques: pre-existing exclusions, the permanent "ridering out" (exclusion) from coverage of the individual, or of a specific benefit and/or condition.

Whole Groups were increasingly profiled and charged varying premiums based on demonstrated or anticipated use of services. The most prevalent methods are called "tiered" and "durational" rating—which were the focus of the NAIC's reform efforts.

Tiered rating is the practice of looking at a group's health experience, conditions or use and placing groups into a pool with others having similar health experience conditions or use. An insurer may have rating tiers at multiple levels. Tiered rating is used most often when setting a group's renewal rates (since insurers have actual claims experience at this time); however, in many cases an insurer may place groups in tiers (for example, a standard or substandard tier) at initial issue based on their health care experience before being covered by the carrier.

Durational rating is the process of charging lower or discounted premiums to newly covered groups and increasing premiums in amounts in excess of the carrier's average cost increases during subsequent years. By establishing low first-year rates, durational rating is used by insurers to attract new groups; however, it also reflects the tendency for an insurer's claims to grow over time as individuals become covered for temporarily excluded preexisting conditions and the tendency for the individuals deemed healthy (by passing initial medical underwriting screens) to get sick and "regress toward the mean." Prior to rating reforms, most carriers limited health status

factors to 2 to 1. Yet in our NAIC debates, we found variances as high as 300% and 400%.

One very important final note: the above factors used in combination, have a multiplied effect. Hence, allowing for full age and gender variances could produce a premium variation of 8 or 10 to 1. If you add geographic variables, you could approach a 15 to 1 spread in rates.

LESSONS FROM STATE MARKET REFORM INITIATIVES

Trying to assure compliance with these or any rating reform has been—and will be—a regulator's (or alliance manager's) nightmare. THERE IS SIMPLY NO AMOUNT OF LEGISLATION OR REGULATION that can completely neutralize the competitive pay-off of better risk selection. Keep in mind that roughly 5% of the insureds produce about 50% of claims expense. Hence, identifying (and avoiding) that 1 in 20 persons will have a BIG impact on a carrier's competitive position and its bottom line!

As reforms eliminate competition based on (subtle) product variation, and as pricing pressures gravitate toward some index or benchmark rate, pressures to find the better risks (somehow) are likely to increase—at least until a more perfect "risk adjustment" mechanism is found. This will be especially true for smaller insurers, who may not have the economies of scale or whose data systems or managed care products and networks may not be as finely developed. In turn, this will require increased vigilance from regulators (or alliance managers). As regulators have identified more and more discreet and pernicious rating techniques in the course of our modest reforms to date, the more subtle other risk selection techniques have become.

As noted, some 40 states have enacted some variation of rating reform for employer groups under 25 (or 50). These reforms have improved market stability, product and price stability, guaranteed renewability, comparability, and lessened price disparity and, hopefully, improved fairness to some degree.

While most reforms have limited premium variations charged due to experience rating, industry classification, and health status of similarly situated groups to around 200%, demographics allowed outside of the bands, may still allow theoretical differences in excess of tenfold. Whether this amount of variation is acceptable as health care increasingly is viewed as a right, is a major policy question. Equally, there are fiscal and social equity questions inherent in rate restrictions.

In short, the current market reforms largely have helped stabilize the existing market by limiting the destructive tendency within the industry to seek only the best risk—to segment the experience pool into increasingly minute and discreet subgroupings. In addition, outside of guaranteeing the availability of a product to a few groups who have been dropped due to health status, inasmuch as these reforms do not deal in any meaningful way with the underlying cost of care (the affordability issue), they will do very little to address the access problems faced by 35 to 37 million Americans —at least in the current voluntary employer-based system. Clearly, far more will have to be done.

Community rating is frequently suggested as a simpler alternative to these admittedly complex rating reforms. Some caution may be appropriate here. Community rating is defined in a variety of different ways by different individuals—a single rate for all or by company? pure community rating vs. "modified" or "adjusted" community rating (the latter may yield a variance of 10 to 1)?

Community rating does not mean lower costs but simply a redistribution of those costs. While who wins and who loses is critical given today's rating practices, as you move toward community rating there invariably will be more "losers" than winners.

While a single rate for all citizens may be desirable in one sense, it may fail the test of economic fairness (for young people with limited disposable income) or social fairness (for persons with healthy lifestyles).

Finally, how fast your transition (compress the rates toward the mean) from the current (widely divergent premium) world to the new world is likely to have some

disruptive economic and marketplace impact. This suggests some premium "shock absorber" or transitional relief for those adversely impacted, as well as consideration of the impact on the market and employment of payers who cannot compete under the new reforms.

Several states like California, Florida, North Carolina, etc. are setting up (voluntary) purchaser alliances. While the re-establishment of broader pools envisioned in alliances will help, HIPC or health alliance managers will no doubt still face risk carriers engaging in risk segmentation/avoidance albeit far more covertly. These problems will be proportionate to: the amount of rate variation/discretion allowed participating carriers; the amount of plan variation (or the supplementation) allowed; the number of carriers; and especially troublesome if these alliances are set within the existing voluntary marketplace. If HIPCs are not to be exclusive, it is critical that the voluntary (non-HJPC market) and the alliance market have similar rating restraints and that their relative impact on remaining pooled risks be periodically evaluated.

Finally, while purchasing alliances hold some cost retardant promise in four or five ways, it remains to be seen whether they will be given sufficient clout and latitude to exact the kinds of fundamental changes (and savings) some hope they will have on the health care delivery system.

THE HEALTH-CARE CRISIS IN AMERICA TODAY: A GROWING THREAT TO ECONOMIC SECURITY

WEDNESDAY, SEPTEMBER 15, 1993

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in room , Rayburn House Office Building, Honorable David R. Obey (Chairman of the Committee) presiding.

Present: Representatives Obey, Andrews and Ramstad; and Senator Robb.

Also present: Richard McGahey, Executive Director; David Podoff, Lawrence Hunter, Morgan Reynolds, and Kathy Seiks, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE OBEY, CHAIRMAN

REPRESENTATIVE OBEY. Good morning. Today, we will continue with our second day of hearings on the troubles in the existing health-care system.

The second panel before us is Mr. Ron Pollack, Executive Director, Families USA Foundation; John C. Rother, Director, Legislation and Public Policy Division, American Association of Retired Persons; Leroy Schwartz, M.D., President, Health Policy International; Sara Rosenbaum, Senior Research Staff Scientist, George Washington University Center for Health Policy Research.

Why don't we begin with you, Mr. Pollack.

Let me ask all of you to simply take whatever time you think is appropriate, and then we will go to questions.

REPRESENTATIVE RAMSTAD. Mr. Chairman, before we begin, I believe we are going to hold to the practice that you established last month, we are going to have at least opening statements from the Chairman and one member of the Minority? That was your stated policy.

REPRESENTATIVE OBEY. We had the opening statements yesterday. If you have something you want to say, please proceed.

OPENING STATEMENT OF REPRESENTATIVE RAMSTAD

REPRESENTATIVE RAMSTAD. Mr. Chairman, I appreciate that opportunity. I appreciate your holding the hearings. I think it is very critical for the Joint Economic Committee to look at this health-care reform proposal from an economic standpoint.

I was disappointed that we didn't hold a single hearing on the tax bill, and I was wondering for a while, as a new member of this Committee, why we have a Joint Economic Committee. But I applaud your leadership in holding hearings on health-care reform. I certainly think it is important that we look at it from a macroeconomic standpoint, as well as from a microeconomic standpoint.

I am concerned, Mr. Chairman, and I am not going to go on long, but I do want to make a couple of points here. A poll that was just released last night showed that two thirds of small businesses now providing health insurance think the President's plan would put more of a burden on businesses like theirs. And I hope that some of the witnesses today address this concern, because it is a real concern.

Yesterday, the National Restaurant Association visited all of us on the Hill and expressed their deep concerns about the mandate, and of course that has been estimated to lead to 3.1 million jobs being lost nationwide. That was done by two respected labor economists. That was hardly a piece of business propaganda. It was done by two respected labor economists from Barch College, namely June and David O'Neill.

We all want to provide access for those 37 million Americans without insurance. We all want to reduce, or at least constrain, health-care costs. And I applaud the Hillary Clinton task force emphasis on cost containment. I think there are some good cost-saving measures in the plan that I have seen, including one proposal that I put forward as a piece of legislation, and others have done likewise, to provide for a uniform reporting form.

I think we need to go to some of these streamlined measures in terms of the administration of health care. But I was astounded, I must say, during the health-care briefing before the Small Business Committee, when Mrs. Clinton responded to a question from Norm Sisisky—one of our colleagues, and a Democrat from Virginia—when he expressed his concern about the impact of the plan on small business; and Mrs. Clinton said, and I am quoting, "I can't go out and save every undercapitalized entrepreneur in America."

I think we have to be very concerned about the impact of the mandate, because most of my friends, most of my constituents who are entrepreneurs are, by definition, uncapitalized in this current climate.

So I am glad we are looking at this from an economic standpoint, because I believe it is imperative that we consider its impact on business, the proposed reform's impact on jobs on the macroeconomy.

So I appreciate the witnesses being here today. Thank you for calling this hearing, Mr. Chairman.

[The written opening statement of Representative Ramstad starts on p.109 of Submissions for the Record:]

REPRESENTATIVE OBEY. I will respond, given the gentleman's statement, by simply making two observations. First of all, the gentleman can do anything he chooses to try and make this a hearing on the President's package. This is not a hearing on the President's package. At this point, I am not interested in the President's package. I am not going to defend the President's package or attack it. We don't have that package yet. Until we do, I don't have any intention of making any judgment on it one way or another.

I recognize that, certainly based on the performance yesterday, there are members of the Minority who are so lusting to attack the President's package before it has even been introduced that they will do anything they want to accomplish that.

The fact is, these hearings were called as the first stage in the consideration of health problems in this country. And the hearings were called first to evaluate the existing system and I guess the naive assumption that if we could have an analysis of the existing system, it might make it easier for us to

eventually reach agreement on some common solutions to the problems inherent in the existing system. That is still the intent of the Chair.

And with all due respect to the gentleman's desire to turn this into a hearing on the President's package, if he wants to do that, he can run his own hearing. But this is a hearing on the existing system, and that is going to be the focus of my comments and questions today.

With respect to the poll that the gentleman cited, I would simply say I am not at all surprised by the results of that poll. It was done by the Association of Insurance Agents. I have been around here long enough to know that organizations can get any poll to say anything they want which suits their own interest.

It reminds me of the study on energy taxes done by the Electric Power Institute, which was used in the debate on the Btu tax on the Floor. It might have been politically fascinating. It certainly wasn't at all unbiased. And I have been around here long enough to know you can find studies to say anything you want, as is evidenced by NAFTA, where studies on both sides use questionable assumptions to reach whatever conclusions they prefer to reach.

So I would simply ask the witnesses to proceed, and I will be happy to have a hearing on the President's health plan once we have it, but the hearing today is hopefully an effort not to quote Hillary Clinton out of context, but an effort to simply try and analyze in as nonconfrontational, nonpartisan, nonideological way as possible, what the strengths and weaknesses are of the existing system so that we have some standard by which to judge how it ought to be changed.

REPRESENTATIVE RAMSTAD. Mr. Chairman, just for the record, no one, especially not this member, is lusting to attack the President's package before it is introduced. If you had listened carefully to my words, I measured them. I am the last member of Congress who wants to politicize this process. I am one of the Republicans to whom Mrs. Clinton reached out to in three small group briefings. I am trying to work with her. I think this is the last issue we should politicize.

I just thought it might be appropriate since everyone in town, even those outside the Beltway, know the elements in the President's plan, that as long as we have these experts and this expertise here assembled, what is wrong with having them comment on the President's plan? If it is your wish not to address that or approach that subject, I will certainly defer to that, but please, Mr. Chairman, don't exaggerate my words. I am not trying to politicize this hearing.

REPRESENTATIVE OBEY. I referred to the hearing yesterday when Congressman Cox described and compared Mr. Clinton's plan with Stalin's collectivization of Soviet agriculture. I call that lusting to attack the President's plan by whatever technique they can grab.

REPRESENTATIVE RAMSTAD. Mr. Chairman, I had a markup yesterday, as you know, and I was only present for the first three or four minutes. So I now understand the Chairman's statement much more clearly.

Thank you, Mr. Chairman.

REPRESENTATIVE OBEY. Mr. Pollack, please proceed.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA FOUNDATION

MR. POLLACK. Mr. Chairman, Congressman Ramstad, I am delighted to be here today. I know that we are going to have a calm and dispassionate debate over the next few months about health-care reform. And I am delighted to lend my voice to that.

Before I talk a little bit about questions relating to the family budget, I do want to provide a preview of a report that we will be releasing this afternoon at the White House with the First Lady, Hillary Rodham Clinton. This report focuses on a burden on American families that is not often articulated.

Often we talk about 37 million or 34 or 35 million Americans without insurance. This report focuses on those people who have insurance and are going to lose it.

The report that we are going to issue this afternoon provides statistics for the first time about the number of people who lose health insurance each month. And the number of people who lose health insurance each month is a little over two and a quarter million Americans.

Each and every month, two and a quarter million Americans lose health insurance, most of them for a temporary period of time. It may be three months or five months or seven months. It may be a year or more. But for these people, they are forced to play Russian roulette with their health and economic security.

As a preview, I might say in your two states, Wisconsin and Minnesota, the numbers are essentially identical. In each of your states, 36,000 people will be losing health insurance each month. These are people who have insurance this moment but will not have insurance sometime next month. And there will be another 36,000 the following month.

I am happy to answer questions about it, but I thought that inasmuch as we are releasing this report today, I might give you a very general preview about it.

Now, you have asked me to focus my testimony on the threat of health-care costs on the family budget. In 1991, we issued a study entitled "Health Spending: The Growing Threat to the Family Budget." It is this report which I am holding in my hand.

This report examined for the first time the total impact of health-care spending on American families and businesses, nationally and state by state, for the years 1980, 1991 and 2000. We looked at direct and indirect health expenditures to produce a comprehensive picture of health-care spending by families.

I should add, we are currently in the process of updating these results and will release the findings in the next couple of months.

Let me add one important caveat about the estimates I am about to give you. They understate the burden of health-care costs on families, since there is no attempt to determine how much of businesses' health expenditures are simply passed back to individuals through either lower wages, higher prices or reduced payments to shareholders. These estimates also do not attempt to account for the cost to individuals of the business tax deduction for health benefit expenses.

Now, let me tell you what our key findings were. Our key findings as of 1991 were as follows. In 1991, the United States spent an average—this is now expenses directly by families as well as businesses—$6,535 on health care per family. By the year 2000, we project that the spending will be $13,911 per family.

In 1980, the average family spent one out of every $11 of its income to support our health-care system. By the year 2000, the average family will be spending one dollar on health care for every $6 in income. Again, this does not include the expenditures that businesses make on behalf of families that indirectly come out of their pockets as well.

In 1980, American families paid, on average, a total of $1,742 for health care. Businesses paid another $830 per family. This amount includes out-of-pocket expenses, health insurance premiums, and state and federal taxes that are spent on health care.

In 1991, that figure rose to $4,296, a two-and-one-half-fold increase. By the year 2000, the average health payment by families is expected to rise to $9,397, more than five times the amount spent in 1980.

The family bears most of health-care costs in America by paying over 65 percent of the bill. America's businesses pick up the rest of the tab, which is less than 35 percent.

Aggregate health spending by families rose from $155.5 billion in 1980 to $456.1 billion in 1991, and is expected to rise to $1.1 trillion by the year 2000, an almost sixfold increase in over two decades.

Family incomes have suffered since 1980 as health-care costs have increased. In 1980, average family health spending amounted to 9 percent of average family income. By 1991, spending amounted to almost 12 percent of average family income. And, if current trends continue, average family health spending would consume 16.4 percent of average family income by the year 2000.

Now, Mr. Chairman, if you would permit me, Congressman Ramstad asked questions about small businesses, and all of us are concerned about small businesses, and I would like to make four brief observations about what I think is in it for small businesses if we can achieve comprehensive reform. Obviously, the concern we have for businesses, with respect to the health-care system, is that health-care costs are skyrocketing, and too many businesses are finding that health care has become, or is becoming, unaffordable to them.

I believe there are four things that America's small businesses want from health-care reform. I will say, incidentally, that I believe the Clinton package is going to offer all of these four forms of relief.

Number one, perhaps most important, America's businesses want to keep health-care spending down. They want to keep costs down. And as we know, the Clinton plan is certainly geared towards making sure that the fast escalating costs are limited so that businesses can have some predictability about costs, and those costs don't continue to soar.

Second, most businesses in this country provide health insurance. Today, the vast majority of Americans receive their health insurance coverage through the workplace. And most businesses today provide coverage.

Now, when they provide coverage, one of the things that they are paying for is not coverage for their employees. A business that is today providing

coverage not only pays for all of that business's employees, it is paying for all the people who are uninsured as well.

For example, Joe's Hardware on Main Street, who has eight employees, provides health coverage. Across town, Jim's Hardware Store, also with eight employees, does not provide coverage. Well, the reality is, if one of Jim's employees drives back from work this afternoon and gets into a car accident and goes to the hospital, even though that person is uninsured, that person will be taken care of. And who is going to pay for it? Joe is going to pay for it. Joe is going to pay for it with cost shifts that his business must bear in order to pay for the uncompensated care of that uninsured employee hired by Jim.

Until recently, in New Jersey, there was an explicit surcharge on all hospital bills of 19 percent to pay for those people who are uninsured. So for the small businessperson who provides insurance coverage today——

REPRESENTATIVE OBEY. Would you say that again? I missed that number.

MR. POLLACK. Nineteen percent. In New Jersey it was an explicit surcharge. In other states, there may not be an explicit surcharge. There is a hidden surcharge. And most Americans know that when they are paying for their health-care costs at a hospital, they are not only paying for themselves, they are paying for all the people who don't have coverage.

And the small businessmen and women of America who provide coverage are bearing those cost shifts. So, if we get coverage for everybody, small businesses that provide coverage today and are bearing the costs of those cost shifts will no longer have to do so.

That is the second benefit that small businesses should expect, and clearly want, from what I understand will receive in the Clinton health package.

Third, small businesses often have a great deal of difficulty dealing with the insurance companies. I can tell you, I have had great difficulty as a small nonprofit business trying to get insurance for my employees. In the last four years, I have not experienced an insurance premium raise that has been less than 29 percent per year. And clearly, I don't have any leverage when I deal with the insurance companies.

So one of the things that small businesses want is to achieve greater leverage vis-à-vis the insurance companies. And by being able to join together in a pooled arrangement for the first time, they will have that leverage possibility. And that too is going to be a significant benefit for small business.

And fourth, many businesses have trouble buying health insurance today, but desperately want to buy insurance. This is because, if you are a business owner, it is likely that you are going to want to get insurance for your own family—your spouse and your children. And the best way to get it is by being able to purchase that coverage in your business place.

For those that have difficulties paying coverage, they are looking for some help in the form of subsidies. This is especially needed for businesses that are at the margin, or are paying their employees relatively small amounts in wages. And so another thing that small businesses want from health reform is subsidies for those who have difficulty paying for insurance. And as I understand it, the Clinton plan is going to provide significant help in this respect.

So, Congressman Ramstad, I must say I share your concern about the interest that small businesses have. It is a concern all of us need to have. And I hope Democrats and Republicans share that concern. I believe that

comprehensive reform is responsive to those concerns. The Clinton plan will be very responsive to those concerns.

So, if I may conclude, let me say that American families and small business owners simply cannot afford the prices they are charged for health coverage. As a country, we can no longer afford to keep Americans guessing about whether health care will be there when they need it. We must enact comprehensive health-care reform that will guarantee that families will never lose their health insurance, no matter what.

And, since Senator Robb recently arrived, let me report that we are releasing a report today at the White House with the First Lady about the number of people who lose health insurance each month. These are people who have insurance now but lose it each month. And it is over two and a quarter million Americans who lose it.

In the State of Virginia, 35,000 Americans lose health insurance each month. It is the fear and loss of security that comes with such losses that comprehensive health-care reform hopefully will address.

Thank you Mr. Chairman.

[The prepared statement of Mr. Pollack starts on p.111 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you.

Mr. Rother, please proceed.

STATEMENT OF JOHN C. ROTHER, DIRECTOR, LEGISLATION AND PUBLIC POLICY DIVISION, AMERICAN ASSOCIATION OF RETIRED PERSONS

MR. ROTHER. Good morning, Mr. Chairman, members of the Committee, Senator Robb. My name is John Rother. I am the Legislative Director with AARP. Today, I would like to run through some of the projections and the data that indicate the urgent need for comprehensive health reform legislation, from the point of view of American families and especially from the point of view of older Americans.

My testimony today is part of our effort to highlight the substantial cost of doing nothing. Doing nothing is by far the most expensive option we have available. It is an expensive option not only in terms of money but in terms of security and in terms of the actual health status of the American people.

We know that most Americans enjoy the benefit of high-quality health care, but we are not getting very much for our money compared to what other countries are able to provide. The system that we have today is fragmenting and the cost is running out of control.

You don't have to look far to see that the current health trends foretell a clouded future without comprehensive reform. Spiraling costs and inadequate coverage will mean more cost shifting, higher costs and lower benefits for families, and continued lack of protection against the enormous costs associated with long-term care.

I have asked Michele Kimball from our office to help me run through a series of 13 charts. They are included in the back of my testimony, but we have the larger versions here for you today, which will summarize the main points I would like to make.

The first point I would like to make is that without health reform, if we don't do anything, if the current system continues on its present course, family

payments, as well as the national costs of health care, will grow substantially in terms of GNP. We are spending today about 14.4 percent of our national product on health care. And that is projected to go to 18.1 percent in the year 2000.

From a family point of view, it is much more dramatic. As you can see here today, the family share of our national health bill is over $9,000 a year. That is projected to go to almost $17,000 per family in the year 2000 if we don't enact comprehensive health reform.

One of the real challenges is to help people understand exactly how these costs affect them. Most people we found are not aware of the true costs of health care as it affects them. They may be aware of their out-of-pocket payments and the cost of premiums, but they are not aware of the other ways in which the health-care bill is paid.

Only about one third of household health-care spending are costs which are visible to consumers today. Two thirds of the spending are hidden costs that show up in three ways. One way is lower take-home wages. A second way is higher prices for goods and services. A third way is higher taxes.

In lower compensation, in higher prices, and in higher taxes, we are getting killed by the ever-increasing cost of health care. It is important, I think, that people understand how much of our health-care bill comes in an indirect fashion.

Without reform, rising health-care costs will eat up another three weeks of the average household's yearly income by the year 2000. Today, we spend over two months of household income paying for our health-care bill. By the year 2000, we will add another three weeks to the amount of time that a family has to pay for health care. That is almost 100 days worth of household income for health care by the year 2000.

Without health-care reform, many families risk being uninsured for a substantial amount of time. Ron just referred to how many people lose insurance each month. This goes to how long they are going without insurance.

We find that it is almost 37 million people who are at any one point without insurance. The myth is that this group is younger, low income, other people, not middle-class Americans. In fact, that is not true.

The risk of being uninsured is also great for people who we oftentimes think don't have a problem. One in four single people without children go for an entire year without health insurance. One in seven people between the age of 30 and 54. One in eight people whose head of the family works full time. One in nine professional service workers go a full year without health insurance. And one in ten employees of large businesses go for a full year without health insurance.

So this is a problem that affects every segment of our society. It is not confined to one particular class or income group, ethnic group, or anything else.

When we think about how many people lack health insurance for one month, we are talking about more than one out of every four Americans over a two-year period, according to the Bureau of the Census.

Now, one month without health insurance is different than one month without income. You can make up the income. But if your child gets sick when you lack health insurance for that month, you cannot get insurance that will cover that condition. It is preexisting. You are out of luck for the entire period of that illness.

When something happens during the one month that a family has no coverage, then they are going to face medical bills that could potentially wipe them out. The fact that they may get re-employed or get insurance coverage again later, generally speaking, does not compensate for the risk that they face when that health insurance is not in place.

I know our tendency here is to talk about the economic effect of health insurance and the costs of health insurance. But the point that I want to make next is that we are talking about a lot more than just money. In fact, and this is not widely known, but a study published by the AMA has documented that those who have no health insurance face a 25 percent higher chance of dying than those that have health insurance.

This is a lot more than just money. It is the fact that people don't get care when they don't have health insurance. They wait longer before getting the care they need. And this has very, very serious consequences in terms of their ability to stay alive.

When we think about people who are working, what we see in the current system is a very pronounced trend. This was documented in the *Business & Health* magazine. Ninety percent of employers that were surveyed plan to either increase the cost to the employee or cut benefits. In other words, the status quo today means that Americans will pay more and get less. This is happening now, and it is happening throughout the employee work force—90 percent of employers.

Without health reform, employees can expect to have their choice of doctor and health plan restricted as employers respond to the rising costs. We know managed care is an option, but this is a chart where managed care is the only option, and employees of these firms are not permitted to choose their own doctor. In 1990, 12 percent of firms had only managed-care benefits available. In 1993, that figure has risen to 3 percent of firms.

So, if we want a health-care system where the American family has no choice of their own doctor, then the status quo is that system, because this means that you must take the plan that the employer offers, or you go without coverage.

Now, we know another part of what faces the family is the care that is needed when someone in the family becomes chronically ill. This is a chart that shows this is not something that happens only to seniors. Individuals of any age can find themselves in need of long-term care services. In fact, the largest number of individuals who are limited in their ability to perform major activities in their daily lives and may need long-term care either at home or in a nursing home are in between the ages of 45 and 64.

You can see here that there are also 2.3 million children who need long-term care services; 6.5 million people between the ages of 18 and 44. Our stereotype is that this is a problem for seniors. It is a very serious problem for seniors. It is a very serious problem for children, younger people and middle-aged people as well. Of course, it is usually their family—the family members are often women who are taking on the burden of care giving, regardless of the age of the person who faces this kind of limitation.

We also tend to minimize the problems facing people who are so disabled that they must consider going into a nursing home. I think a common statistic in our denial of this issue is that only 5 percent of older people are in nursing

homes at any one point. And that is true. But that substantially understates the long-term risk we face in our families of needing nursing home help.

In fact, one out of two women today will spend some time in a nursing home. One out of three men will spend some time in a nursing home before they die. For their family facing that cost, which is over $30,000 a year and in some areas up to $60,000 a year, this is no different from the costs of a household stay or the costs of seeing a doctor. This is catastrophe, and people need to have some kind of backup protection.

REPRESENTATIVE OBEY. Pardon me for interrupting, but if you can leave that chart up there for a second, do you have any information as to why you have 50 percent of 65-year-old women as opposed to 1 percent of 65-year-old men? Is it just that women tend to live longer?

MR. ROTHER. It is good news and bad news. Women tend to live longer. Men are prone to heart attacks and the kind of illnesses that cut them off at an earlier age. So women are more likely to survive into the years where chronic illness takes away their ability to live independently.

Another very important area of the economic impact of this is the cost to a family of necessary prescription drugs. We saw the price of prescription drugs more than double during the last decade.

The key point I want to emphasize here is that 72 million Americans today have no coverage for the cost of prescription drugs. These drugs are in many cases essential to staying alive or staying productive. The costs are getting to be at the point where, for most American families, they cannot afford to pay completely out-of-pocket, if they have more than one continuing condition like, for instance, hypertension or arthritis, or things where you need to have a constant dosage in order to keep you functioning. So we are looking at prices going out of control, and 72 million Americans with no protection whatsoever.

Now, why don't we just solve our cost problems by cutting back further on Medicare and Medicaid, or enacting an entitlement cap on those programs and just deal with the program that way? The problem is that health care providers have shifted costs to private sector payers. What we have found is sometimes described as a balloon, where you squeeze at one end and the costs just end up at the other.

Today, when we look at payments for hospital care, we find that Medicare is paying at about 68 percent of what private insurance pays hospitals. This imbalance will continue as the budget agreement puts limits on hospital updates.

Unless we do something about cost containment on the private-sector side, we are kidding ourselves. We are not helping the economy by controlling health-care costs.

There is a downside to cost containment that goes beyond just the inability to help the economy. It is a threat to access.

Today, the restrictions on the payment rates for Medicare and Medicaid are beginning to seriously threaten access to care. A doctor who receives $100 for care delivered to a private patient is receiving, on average, 35 percent less when he sees a Medicare patient, 45 percent less when he sees a Medicaid patient.

As a result, many doctors today refuse to see Medicaid patients at all, and we are seeing many complaints from our members about doctors who are now beginning to refuse to see Medicare patients.

The differential between what public programs pay and what private-sector programs pay is the key issue here to maintaining access, and that differential is growing. It is a very serious threat that must be addressed in comprehensive health-care reform.

In summary, we have a health-care system today that is on a breakdown course. It is falling apart. It is getting much more expensive, more expensive to the economy, more expensive to American families. It is a threat to their health as well as to their pocketbooks. And if we can agree on anything today, I hope we can agree that the status quo is not an acceptable course for this country to take.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rother starts on p.128 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you.

Dr. Schwartz, please proceed.

STATEMENT OF LEROY L. SCHWARTZ, M.D., PRESIDENT, HEALTH POLICY INTERNATIONAL

DR. SCHWARTZ. Thank you, Mr. Chairman.

I notice from your paper that what this Committee is interested in doing is exploring the historical evolution and the particular attention being paid to the economic significance of escalating health-care costs as it impacts upon different segments of American society.

I am going to deviate from what has been said up until now, that includes yesterday, and say that health-care and health-care costs really are a part of a bigger problem that exists in this country. Mark Stanton is going to put up some charts which illustrate this problem. Thank you very much for making them. As you can see, they are not in technicolor.

Last year I gave a talk at a conference, and unfortunately the person before me gave my talk. That was okay, he gave me credit, but nevertheless I wasn't quite sure I had enough to say. The speaker said that he had recently spoken with many Americans, and all of them said that the health-care system is broken, it has to be fixed, it is costing too much, on so on.

And I thought, well, I will speak about that, because basically I think that if you ask any American how the education system is faring, you will find out that they think that the education system is broken, it costs too much, needs radical change, it has to be fixed. And I also asked them, what do you think of our criminal justice system? And they said, well, it is broken, it has to be fixed, it costs too much money, and we are not getting anything done. And I also asked them what they think of our immigration system. And they said, well, the immigration system is broken, it has to be fixed, it is costing too much money, it has changed tremendously.

I came to the conclusion that an awful lot of our systems that worked before, such as education, welfare, criminal justice, health care, don't work now for some reason. One of the reasons I think these systems are broken is due to the tremendous social changes in this country, and that the load of pathology, for instance, in the health-care system that has to be taken care of has increased tremendously over the last 25 years.

The first chart actually shows what we believe to be happening in this country, that social problems are playing a major role in the cost of health care, and not only playing a role in the cost of health care, but in all the other systems together. It also indicates that the middle-class family, by and large, is paying the bill for everybody.

As you can see from this chart, we have socioeconomic factors which exist in this country today: poverty, unemployment, poor housing, undernutrition. People who are poor are sicker. And sicker people require more health care.

This country has more poor people than virtually any industrialized country. We have, according to the government, about 15 percent of our population is living under the poverty level, and according to the Urban Institute, 20 percent are living under the poverty level. Twenty percent of our population translates to 50 million people in poverty. In addition, we have those just above that whom we refer to as moderately indigent.

We also have a set of behavioral risk factors, including drug abuse, violence, unsafe sex, AIDS, which are almost unique to this country. They do occur in other countries, but they certainly don't occur to the same extent in those other countries—countries which we are often compared with, Sweden, Switzerland, Canada and Germany—as they do here. They all end up in the emergency rooms of our hospitals, and they all are paid for through the health-care dollar.

One of the things that we should be doing is trying to cut down on this altogether. But the main thing is that the pool of pathology in this country is increased by the incidence of the extensive need for care in both of these groups, and it is very, very high.

This pool of pathology, as you see, then goes into the health-care system. It is acted upon by providers and payers, as well as from the system from which we expect access, quality and lower cost. But in the meantime, we are raising the amount of pathology that goes into the system for reasons which do not depend initially on health care. They depend on socioeconomic factors and on factors which we would call behavioral risk factors.

One can look at any city in this country, and in fact you can look out your window at this city, you will see that the inner city is often falling apart and people are very sick. They are, in effect, needing intensive care.

The next chart is an approximation of what it costs this country to pay for items which ordinarily wouldn't be considered directly attributable to health-care costs in other countries. For instance, we have the medicalization in this country of social problems: gambling, smoking, drug abuse, rehabilitation, alcohol abuse, unsafe sex, AIDS, homicides, assaults, rape, tuberculosis. They are costing a tremendous amount of money in the health-care system, and this country is paying for it. And when we compare ourselves to other countries, other countries don't have that to the same extent.

So they don't have to pay. They don't need the intensive care that Americans need. When an American goes into a hospital, he is very sick. When a Swiss goes into a hospital, he is not as sick.

We also have tremendous medical indigence problem and a poverty problem. These people are a sicker population; they require increased care and cost because of later attention to problems, lack of immunizations and lack of preventive care.

In addition, we have another special problem in this country. We have the cultural attitudes of our society. We try to save every high-risk baby. In other countries, they don't. That is a decision that should not be made by the medical profession. It is a societal decision. And it is being put into the field of health care, and is costing us a tremendous amount of money.

The elderly, in the last few months of their lives, spend a tremendous amount of money on life-prolonging efforts. Many times, they don't want these efforts expended to themselves, but we do them anyway, and according to some estimates, this costs about $30 billion.

Of course, we have fraud and abuse in this system. The last estimates from the government were about $80 billion. This year, it should be about $90 billion.

If you put this all together, you have about $900 billion as the cost of care. Social costs, which run about $300 billion, are ordinarily in the social budgets of other countries. If we were to subtract the costs and pay for them in a different ledger, we would find the health-care costs in this country are not nearly as high as they seem to be.

I don't believe that infant mortality rates, which are often used in this debate, are really a good measure of our health-care system. The next chart shows infant mortality rates in a somewhat different way. These are the best countries in terms of infant mortality rates. They have the lowest infant mortality rates in the world. And compared to the United States, they are in fact much lower.

Now, if you look at them in a different way, if you look at infant mortality rates by states, because many of our states in fact are larger than these countries in population, you find a different story entirely. You find that our infant mortality rates by state are much lower than other countries, or in the range of other countries' best efforts.

Therefore, the question is whether it is demographics, or in fact has something to do with our health-care system. As you noticed on the state chart, there are no Southern states that have a low infant mortality rate. Yet, they have the same health-care system, and their infant mortality rates would not put them into the best group.

REPRESENTATIVE OBEY. If I could interrupt, I am going to have to ask you to do the same thing I asked Mr. Rother to do. If you could sum up in about two minutes so that we could hear from Ms. Rosenbaum; otherwise, we are not going to have time for questions before you have to leave.

DR. SCHWARTZ. I don't have to leave.

REPRESENTATIVE OBEY. But we have another panel, and we would like to put on the last panel.

DR. SCHWARTZ. I am sorry.

The last thing I would like to show is that there is a question of America doing poorly. America is not doing poorly, as I showed from infant mortality rates by state. If we take a look at these conditions, which come from the World Health Organization data, we find that in almost every case, America has a lower mortality rate for conditions amenable to medical and surgical intervention. And there are indeed regions for that and we have to explore them, and we shouldn't lose this edge by changing the system entirely.

So basically, what I would like to say is that there are many factors that play a role out of the usual discussed factors, and the major one, I believe, is that the demographics of this country are very different than most other countries. To make any comparisons could be counterproductive, particularly to the poor in this country.

Thank you very much.

[The prepared statement of Dr. Schwartz starts on p.147 of Submissions for the Record:

REPRESENTATIVE OBEY. Thank you.

Ms. Rosenbaum, please proceed.

STATEMENT OF SARA ROSENBAUM, SENIOR RESEARCH STAFF SCIENTIST, GEORGE WASHINGTON UNIVERSITY, CENTER FOR HEALTH POLICY RESEARCH

MS. ROSENBAUM. Thank you very much for this opportunity to testify today.

I am here on behalf of the many clients I have represented over the 20 years that I have been in practice. And you have heard very sobering statistics today from Mr. Rother and Mr. Pollack. I want to try and give you a more personalized sense of the kinds of cases that I saw and that undoubtedly you know in your own districts, your own states, that should be uppermost in your mind as you deal with these very serious problems.

These are the families who are the 2 million a month who either lose their coverage, or in addition to the ones who are losing their coverage, find that the coverage they have is basically worthless, unuseful for the conditions that they or their family members face.

The kinds of cases that have presented themselves to me over the years are a road map to the kinds of issues you need to consider in legislation. They include the affluent family that experiences the birth of a child with a catastrophic health condition, who in the first 60 days of life basically exhausts the family's lifetime benefits for that child; there is nothing left. The family is technically insured. They might as well be one of the 2 million families that is in the pool shown by Families USA.

There is the well-paid worker with four children, one of whom has juvenile diabetes, who loses a job, goes back to a new job, only to discover that the child cannot get any coverage at all because of a preexisting condition.

A case that I dealt with not more than a year ago of a very healthy pregnant accountant, well paid, well insured, who during her labor and delivery suffered a stroke, ended up in a hospital for months, ended up in a rehabilitation hospital for months, no coverage, no coverage for rehabilitation services at all, and basically has a policy that does her no good.

Similarly, the parents of a young girl who was a wonderful, brilliant, beautiful young girl who went off to college and developed schizophrenia, which of course is a late adolescent onset condition. The family has been utterly impoverished by the girl's schizophrenia; no medical health coverage at all.

The father of twins, a very affluent attorney, he had twins born of Downs Syndrome, which is a condition that causes retardation. There is a heightened risk of complicating medical problems in this case. There was no evidence of any health risk. The family was told that if it did not remove itself and the twins from the insurance pool, everybody else in the small boutique law firm would lose coverage. The family is now basically without coverage for its

children in a high-risk pool, luckily, because it happens to live in a state with a high-risk pool. There is absolutely no evidence that there was anything wrong with these babies at all, other than the fact that they had Downs syndrome. An actuary decided that basically there was a heightened risk of heart problems.

And finally, the working mother of three whose husband had abandoned her. She is a secretary. She called my office only a few weeks ago to find out whether I thought she should buy health insurance. She can't pay the family premiums her employer charges her. Her husband has left her with no support whatsoever. Buying health insurance for her children basically takes most of her rental income. She is also caring for a 76-year-old mother.

These are the kinds of cases I see that are not low-income cases.

I have to note a couple of things about Dr. Schwartz's testimony. I would be remiss if I didn't.

I think it is one of the great ironies of life that even if the problems we think of as related to poverty—and I stress poverty, not race, ethnicity or demographics—one of the great ironies is that the poor are less likely to get health care. The babies who are discharged from neonatal intensive care units are more likely to be well-to-do white infants. Study after study shows that if you are publicly insured, uninsured, poor, you are less likely to get admitted for the services in the first place, and if you are committed, you are less likely to stay there. It doesn't matter if you are an infant, or a disabled adult, or an old person.

So putting aside the fact of whether poverty contributes to the cost of health care in the United States—it most certainly does, I don't think anybody would dispute that—that does not translate into health care for poor people.

Second of all, I think that Dr. Schwartz's testimony underscores that if we are serious about health costs in the United States, we have to accompany health reform with other reforms that are designed to deal with underlying problems related to poverty.

We can't even begin to fund those reforms unless we do something about the cost of medical care. Much medical care cost has to do with pricing. Much of that cost has to do with advanced technology, which is not the technology, other than what you might find in an emergency room, that goes disproportionately to the poor; in fact, it goes disproportionately to those of us sitting in this room testifying.

So I would say that at bottom Dr. Schwartz' testimony is a great testament on behalf of not only health reform, but an attack on homelessness and poor nutrition and poor education and the other problems that affect Americans today.

[The prepared statement of Ms. Rosenbaum starts on p.151 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you.

Congressman Andrews, please proceed.

REPRESENTATIVE ANDREWS. Thank you very much, Mr. Chairman.

I would just like to ask the whole panel to address something. I am sorry I didn't hear all of your testimony, but I have a chart which is part of Mr. Pollack's testimony.

Looking at my State of Texas, at the increase, it is the fine print on table 2, but it shows that the increase in health-care costs per family is 128 percent between 1980 and 1991, and the increase from 1980 to the year 2000 is estimated to be, it looks like 390 percent.

I am really curious to ask all of you about your thoughts, because I really believe in what Ms. Rosenbaum said. It is a function of so many other factors as well that impact families.

My state's welfare benefits, for instance, are maybe 49th in the country. And at a time when in my City of Houston, one out of every four babies is born into poverty today, the health-care problems really fall on the poor more than anybody else.

I would like you all to expand for a second, in addition to direct health-care costs that really are creating a terrible dilemma for families. We don't collect child support very well, and we have low welfare benefit states like Texas. Are those states more impacted by health-care costs than states that do more in the area of welfare benefits, other child support collection services? Does Texas get hurt more because we don't do a better job in some of these other areas?

MR. POLLACK. I am not sure that I really feel comfortable, Congressman Andrews, correlating health-care costs based on poverty. I don't think that is the driving engine of this cost crisis. And I think we really make a mistake, as I believe Dr. Schwartz made an enormous mistake, in trying to look at the problems with our health-care system essentially from the prism of poverty. Poverty clearly exists, and it clearly needs to be corrected, but that is not the cause of our health crisis.

The problems that people are experiencing, and the reason this is a health-care crisis today, is not because of the poor. The poor have had problems with the health-care system for many, many years. And I don't think that has changed dramatically. What really has changed dramatically is the impact that health-care costs and insecurity have had on all the rest of the American public. I suggest to you that is why we now have a political crisis, and why health care is right near the top of the political agenda.

You weren't here when I cited a report that we are releasing today with the First Lady at the White House, showing that two and a quarter million Americans lose health insurance each month. In the State of Texas, which is second highest in this respect, there are 173,000 people who lose health insurance each month.

The bulk of these people are not poor. By and large, the people who are losing insurance are people who are full-time workers, they are middle-class people, and they are losing their insurance for a variety of reasons.

I would suggest six reasons. Number one, they lose insurance when they switch jobs. Second, they lose health care when they are laid off from a job. Third, they lose insurance when their employer no longer can afford to provide coverage and the employer drops insurance coverage. Fourth, they may be young people who are graduating from college who no longer are eligible to remain on their parents' policies. Fifth, they are people who may have become sick and insurance companies have dropped them from their plans. And finally, there are people who have been paying premiums all along, but are finding those premiums are skyrocketing.

As I recount each of these different situations, you can visualize people who are middle class, not the poor. The poor essentially either haven't had coverage for a long period of time, or are getting their coverage through the Medicaid program.

And although Medicaid expenditures have been raising in ways that I think none of us in this room are happy about, it is not due to the fact that Medicaid beneficiaries are getting better health care. Medicaid and Medicare beneficiaries, as John Rother's slide showed, are bearing the brunt of Medicare and Medicaid price compressions that have not been paralleled by compression in private-sector prices.

It means that for the poor and for senior citizens and people with disabilities, increasingly they are finding it more difficult to get into the door of a doctor or to get into the door of a hospital. As the disparity increases in how doctors and hospitals are paid by Medicaid and Medicare versus what they receive from private insurance, it becomes less and less desirable to treat poor people and seniors.

REPRESENTATIVE ANDREWS. What does tend to happen then is that they go to the emergency rooms where the cost to taxpayers is enormous proportionately, where women take their children to the emergency room because they have the flu.

MR. POLLACK. Yes, and it means that all of us who are paying for insurance, or employers paying for insurance, are bearing the burden of cost shifts. And it is a hidden surcharge.

REPRESENTATIVE ANDREWS. Dr. Schwartz?

DR. SCHWARTZ. That is what I am saying. I am saying our people are sicker and somebody else has to pay for them. That is all. There is nothing wrong with that.

But I would like to just quickly read something, if you don't mind.

> We must face the biggest exploder of the deficit and perhaps the biggest human dilemma America faces, and that is the health-care crisis. We are spending an awful lot of money and we should be spending more, for a number of reasons. Number one, we do more medical research. Number two, we rely on more high technology. And number three, we have a more diverse population with more poor people than most other advanced countries. More cases of AIDS than most other countries. And we are a more violent country than any other advanced country. So we pay more money keeping emergency rooms open on the weekend for people getting shot and cut up. We cannot get our costs down to the level of other nations unless we make changes dealing with these big structural things.

It sounds like me. It is not. It is President Clinton two months ago. And he basically is saying the same thing. We haven't heard too much about it. But in fact he understands that this country is different, and that we have special problems that are not necessarily related to health-care costs and health care alone. They are social problems.

Yesterday, the Chairman heard that the hospital costs are paid by 50 percent of the population. Is that true? That is what I understand was stated yesterday. That means that 50 percent have to pay for themselves and for the other 50 percent. And yesterday, the number given was that 37 percent of the population cannot pay $3,000. I agree with that. That is one of our problems.

REPRESENTATIVE OBEY. If I can interrupt, I am told by staff that what was said by the witness yesterday is that they expect that by the year 2000, 50 percent of the care in that state will be uncompensated.

DR. SCHWARTZ. That is right. It won't be uncompensated. It will be paid, but not paid by the same people receiving the care.

REPRESENTATIVE OBEY. You know what I mean.

DR. SCHWARTZ. Right.

REPRESENTATIVE ANDREWS. Ms. Rosenbaum?

MS. ROSENBAUM. I was only going to add that I think the reason why costs are going up so dramatically for people in Texas probably has the most to do with the high number of uninsured people you have in Texas; that as long as you have this many uninsured people, those remaining people with insurance are going to see their costs go through the roof.

And the only way to bring down the price of insurance to those individuals, without dealing, of course, with all the underlying causes of high medical costs in the country—that is an additional problem—is to make sure that everybody has insurance, and that everybody pays his or her fair share for that coverage, and that the cost of care is spread over the population.

I haven't worked in Texas in a couple of years now, but my recollection is that, except for Oklahoma—I think you are the state with the highest proportion of uninsured—it puts a phenomenal burden on the people who have the coverage.

REPRESENTATIVE ANDREWS. Thank you very much.

Mr. Chairman, thank you.

REPRESENTATIVE OBEY. Thank you.

Dr. Schwartz, just a moment before I get to questions, I guess I would raise a question about one comment you made. You asserted essentially that when Americans get sick, they get sicker than other countries.

I showed these charts yesterday, and I think I ought to do it again today. Because I know there is this feeling that a lot of the cost of health care is driven by overutilization by Americans. And I just want to show that this chart demonstrates which country spends what as a percentage of GDP. As you see, the United States is up here at 13 percent of GDP that we spend on health care; Britain, 6; Japan, 6.8; Sweden, 8.6, which you mentioned.

But then, if you take a look at utilization patterns, the annual number of physician visits per capita in the country, United States, 5.3; Germany, 11; Japan, 13.

Hospital admission rates percent of the population in any given year, a little over 13 percent for the United States, 19 percent for Sweden, 23 percent for France.

Average length of stay in the hospital—9 days in the United States; Germany 16 days; Sweden, which you mentioned, 18 days. It appears to me that if they are staying in the hospital 18 days and we are staying in the hospital 9 days, if their hospitalization rate is 19.6 percent as opposed to 13.7 in our country, there has got to be something else happening besides Americans getting sicker than Swedes.

I just want to ask you one question. When you talk about the impact of demographics on American health care and the impact of social problems on health care, and you are quoted as saying: "The well-known tendency of

minority patients to put off seeking preventive and curative care." Can you tell us what percentage of African Americans have private health insurance compared to whites?

DR. SCHWARTZ. I don't know the number, but it is less.

REPRESENTATIVE OBEY. My understanding is that 80 percent of whites have private health insurance, 59 percent of African Americans. For those over 65, I am told that 77 percent of whites have private health insurance, 39 percent of African Americans.

It would also seem to me that it just might be possible that one of the reasons that they don't receive good health care is because they don't have health insurance to begin with.

DR. SCHWARTZ. Might be. I think it does. I think they all should be insured.

REPRESENTATIVE OBEY. Let me ask all of you, because there is the argument being made that somehow you can deal with the rising cost problem without having universal coverage.

Does anybody at the table believe that you can effectively control health-care costs without having universal coverage? Anybody disagree that you need universal coverage in order to attack those costs?

MS. ROSENBAUM. No.

DR. SCHWARTZ. I just wanted to address your charts for a second, if I might.

REPRESENTATIVE OBEY. Sure. But first, can I get the answer to this question? Do you disagree with that?

DR. SCHWARTZ. I would like to see everybody covered. I don't know if it costs less, though. We have never done it.

REPRESENTATIVE OBEY. I don't know what it is going to cost. I don't believe anybody's numbers. My question is, does anybody believe that you can control health-care costs without universal coverage?

MS. ROSENBAUM. No, not unless we are prepared to absolutely completely deny care to people who have no way to pay. And I don't think this country is prepared to do that.

MR. POLLACK. I don't think that we can control fast-rising costs as long as we continue a shell game, where costs are shifted from one payer to another. We have to be more explicit about who should pay for specific costs if we are going to control health spending. Everybody is going to have to get coverage so that everybody explicitly knows what is their part of the bill. Continued cost shifting is not going to permit that.

REPRESENTATIVE OBEY. Dr. Schwartz?

DR. SCHWARTZ. I was going to say that coverage is one way of putting it, but coverage is not provision. You can give a person a health insurance policy and then not provide all the care. So I would like to know whether we are talking about provision, or are we talking about coverage where somebody else determines what care they are going to get?

REPRESENTATIVE OBEY. Well, I am talking about covering everyone in this country with a basic comprehensive health-care policy so that at least, in my view, there would be considerably less incentive for the kind of cost shifting that operates in every health institution in my district.

DR. SCHWARTZ. I agree that everybody should have basic health coverage. But I don't know what it is. And if I might, again, address some of your

charts, the situation in Germany is that the hospitals get paid on a per diem rate; that is, they are paid the same amount for each day. So, if intensive care is used in the first three days, the only way the hospitals can get paid is for them to keep the people in the hospital for another week. That is the reason that that length of stay is higher in those countries. We have been trying over the years to get length of stay down.

REPRESENTATIVE OBEY. Cost of care is higher in those countries?

DR. SCHWARTZ. Length of stay is longer. We have been trying through years of DRGs, and we are getting the length of stay down. I thought that what we wanted to do was rather than lengthen the stay, to decrease the stay, and that would be more efficient.

I believe that the reason, or at least in part, we spend far more money is what I said originally, that we are sicker, and that the use of new technology, which we use more than any other country, for those people is also costing us extra dollars. And that is why we may have to spend more money, not less, to bring certain populations into the covered area.

REPRESENTATIVE OBEY. Thank you.

Let me ask Mr. Pollack. We have often heard that you cannot get a handle on costs as long as we don't deal with the problem of overutilization because so many Americans simply rely on third-party payers, and therefore they don't have any real financial stake in keeping the cost of a system down, and therefore we ought to be aware of anything that provides an expansion or third-party payer.

As Mr. Matthews testified yesterday, the cost to the average family, I think he said, was somewhere around 20 percent.

The way you framed your numbers lays it out quite differently. You indicate that the cost to an American family is around 65 percent of overall health-care costs. And you do so by laying out the additional out-of-pocket costs that people have, the costs that they have by way of paying taxes to support health programs and the like.

You said that in Wisconsin in 1980, the average family paid 9.2 percent of their income for health care. In 1991, that figure rose to 12 percent. You said by the year 2000 you predicted an average family in Wisconsin would be paying $9,337 for health costs, which is an increase of 136 percent between 1980 and 1991, and a 400 percent increase between 1980 and the year 2000. And in the year 2000, you estimate that families in Wisconsin will be paying $18 billion plus to finance the health-care system, and that business will be paying another $9.7 billion.

What do you think the average employer-provided health plan will look like if costs are that high by the year 2000? How much do you think those plans will have been shredded by economic pressures on employers if the existing system continues?

MR. POLLACK. I think John Rother addressed that question with one of the charts that he showed us. Employers really have two choices if they want to deal with prices under current circumstances. One choice is for them to cut back on coverage, and many of them are doing that. The other choice is to pass on more of those costs to the workers. And many employers are doing that as well. And many are actually utilizing both of those mechanisms.

Increasingly, we have seen, and will continue to see, employers, who feel so burdened by escalating costs, shifting those costs in one way or another on to

the backs of their workers, either by not covering things that used to be covered or making employees pay a high share of co-payments, deductibles and premiums.

So, for more and more employees, their coverage is going to be far less significant than it is today, and more and more will be in jeopardy.

REPRESENTATIVE OBEY. Let me ask one last question. I noticed in this morning's paper, the *Post* headline, GOP to announce health plan emphasizing gradual, voluntary changes. I don't object to that. I welcome that, any time anybody is offering any plans to change the status quo. But I have one question.

The article said that Senator Chafee indicated that the plan would bring universal coverage in six or seven years without requiring that all firms buy insurance for their workers, or allowing the government to put a lid on increases in private insurance premiums.

Do you believe that it is going to be possible to control costs without some kind of direct government limitations on either insurance premiums or what providers can charge, and do you think that you are likely to see us achieve universal coverage if there are merely tax incentives as opposed to a requirement that employers provide coverage for all people?

How close do you think we can get to universal coverage; in other words, if we simply relied on incentives as opposed to requirements?

MR. POLLACK. Let me first say that I welcome Senator Chafee's proposal. I disagree with significant aspects of it and would like to see it strengthened, but I don't want to start by criticizing the Senator, because I think he is going to play a very constructive role, and he is clearly trying to make this a bipartisan effort. That is very necessary.

REPRESENTATIVE OBEY. I don't ask the question to in any way criticize his plan either, but I think there is a legitimate debate between parties about whether you can reach our goal through one technique or another.

MR. POLLACK. I agree with that.

REPRESENTATIVE OBEY. I am just curious as to what your reaction is.

MR. POLLACK. I think we have three policy choices. One choice is that we don't do very much. I think all of us in this room reject that. The second choice is that we ask individuals to buy care with employer assistance. To make this work, government will have to pay more in the form of subsidies for people having difficulty making payments. Or the third choice is that we ask more of us to share the load, which is really the Clinton approach, that requires every employer and employee to pull a fair load.

I believe that the third approach is the most practical one to achieve coverage for everyone. I don't believe that placing the full burden on individuals will get the job done, and it will require major new taxes to make this approach work.

The second approach embodied in the Chafee plan will require major sliding-scale subsidies. I have fears that the sliding scale will be inadequate for people, particularly as we reach above the poverty line. If the subsidies are low, they will be wholly inadequate for them to afford the insurance that they need, which they would be able to afford if the employer paid a more significant share of those costs.

So I don't know what the numbers would be under the Chafee approach. But I don't believe we are going to come close to achieving universal coverage under that approach.

MR. ROTHER. Mr. Chairman, two additional points. One, based on psychology, one is just the administrative approach. The psychology point is that many of us today are simply in denial about whether we will ever get sick or need health care, particularly younger people who oftentimes have well-paying jobs, are among the uninsured. It is not because they can't afford it; it is because they would rather spend the money on vacations or immediate gratification. This has social cost, and this causes a fragmentation of the system. And it has to do with really not taking some responsibility for yourself. And I think that has to, at some point, socially enforced, because we are otherwise all going to be liable for the cost of their care.

The second point is administrative. I think where the Republicans may be heading under Senator Chafee's leadership is toward the idea of an individual mandate rather than a business mandate. While I think in theory an individual mandate is capable of requiring coverage for everyone, it is quite awkward and expensive to administer and enforce compared to an employer mandate. And I think if they really were to add in all compliance costs of an individual mandate, it would not look like it would save nearly the kind of money that a system based on an employer-type mandate could save.

REPRESENTATIVE OBEY. I just have to observe, I was back in my hometown this last weekend at an arts festival, and my family used to run a pretty good-sized restaurant in my hometown. I used to work in it. And one of our former competitors, he is now retired, came up to me and he said, You know, Dave, I have just one comment. If I were still in the business, my only request to you would be—frankly I hope you don't do it, I wouldn't want to have to worry about picking up the cost these days—but I will tell you, if you are going to do it, just make dog-gone sure that if I have to do it, my competitor has to do it too. And that is what I am getting an awful lot of.

Well, I know at least three of you have to leave. Thank you all for coming. I appreciate it.

MR. ROTHER. Thank you, Mr. Chairman.

MS. ROSENBAUM. Thank you.

REPRESENTATIVE OBEY. Next, could I ask Marilyn Moon, Senior Research Associate, Urban Institute; and Deborah Chollet, Director, Center for Risk Management and Insurance Research, Georgia State University, to address the Committee.

Ms. Moon, please proceed.

STATEMENT OF MARILYN MOON, SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE

MS. MOON. It is a pleasure to be here today to testify on the pressures facing American families because of rising health-care costs.

This is not necessarily a pleasant issue to testify about, because these are very tough problems. But it is an important time to talk about these issues. We face some real opportunities to bring about change, and I think that is very encouraging.

My testimony makes two main points. First, all rhetoric aside, the rapidly rising burdens of health-care spending are borne by American families in the

end, and it is those families that are going to be very much concerned about what happens to their health-care costs over time.

Second, the status quo is becoming increasingly insecure, and in part because of the rising cost of health care and the availability of insurance, these two things are inextricably linked.

National spending on health care has been rising dramatically in the United States in recent years. Since 1965, when we were talking about $43 billion of health-care spending, today we are talking about $940 billion.

Consider spending from the standpoint of individuals. We spent about $112 per capita in 1963. That figure in 1993 is probably around $3,050. And what individuals pay out-of-pocket today is essentially the same share of their income as what the total spending on health care was in 1963. It is a larger and more important share of all of our incomes today.

It is also easy to focus just on the out-of-pocket costs and those costs that people pay in premiums for their own insurance. That is somewhat misleading, because Americans as taxpayers, as purchasers of goods and services, and as wage earners, also bear costs that affect employers and the government.

That is not to say, however, that it is unimportant to look at government-provided insurance and employer-provided insurance, because such insurance plays a critical role in spreading the risks across individuals, so it is not just single individuals who must bear the risks, whether they be $1,000 in a year or $25,000 in a year.

Moreover, we know from studies that those who lack coverage have a harder time getting good health care. They don't get as much health care, and their outcomes are not as good as for those who have insurance.

Those who claim that care is still available in the United States for those who lack insurance are correct. But care is not always available in the quantity or the quality that we would like to see all Americans have access to.

The insecurity of the status quo is also a problem; in part, because when people say, "Let's not upset the apple cart, let's stick with what we have got, it is a good system," they forget that is not necessarily a good system for everyone, and it is becoming a lot less secure for most of us. The percentage of people covered by employers is declining so that people must either buy insurance themselves, or risk being uninsured or depend on government programs. Moreover, employer coverage is increasingly being eroded by employers' concerns about the costs of health care, so they place more restrictions on the insurance, or require more deductibles and co-insurance from individuals. All of these mean that what we have traditionally thought of as our health-care system is changing very rapidly.

It is no accident that these kinds of changes are occurring in the private-sector right now. Because of the rapid rise of costs, employers are simply reacting very reasonably and responsibly in terms of trying to seek ways to lower costs. But someone ultimately ends up paying. And unfortunately that means that there is less security for Americans, creating a growing problem.

Not only is this a period of time in which need is already great, but our prospects for the future are not very bright. The status quo is changing so rapidly that our firm foundation of employer-sponsored insurance is increasingly being weakened, and Americans quite rightly perceive that now may well be the time to change our health-care system, because we are not protecting a lot of things that we have all come to hold dear.

Thank you.

[The prepared statement of Ms. Moon starts on p.154 of Submissions for the Record:]

REPRESENTATIVE OBEY. Thank you.

Ms. Chollet, please proceed.

STATEMENT OF DEBORAH J. CHOLLET, DIRECTOR, CENTER FOR RISK MANAGEMENT AND INSURANCE RESEARCH, GEORGIA STATE UNIVERSITY

MS. CHOLLET. Mr. Chairman, I want to thank you for the opportunity to talk to you this morning.

My testimony is somewhat different from that which you have heard to this point. It steps back from the issue of health insurance coverage, and in particular employer-based coverage, and looks at the macroeconomic dynamics of what has gone on in the labor force over the last five to ten years.

My full statement has a large number of tables and charts in it, which I will synopsize for you this morning, but I refer you to those at your convenience.

I would like to summarize my statement in terms of four major points. First, health insurance as an employee benefit is eroding among the U.S. work force. Between 1985 and 1991, the U.S. economy gained nearly 9 million jobs, but lost 1.2 million jobs that carried health insurance as an employee benefit. Since 1988, the loss of employer-insured jobs has accelerated.

Second, the loss of jobs that provide health insurance as a benefit affects not only the worker that had that benefit, but the worker's dependents as well. For every 100 workers with coverage from their own job, another 100 people are covered as dependents of that worker. On average, 3 of those 100 workers are also workers in jobs that do not offer health insurance as a benefit. Including dependents coverage, about 2 million fewer Americans under age 65 are covered by an employer-based health insurance plan now than were covered in 1985.

As a result, the proportion of Americans under age 65 covered by an employer-based plan has dropped from 75 percent in 1985 to 72 percent in 1991. My guess is that when we see the numbers for this year or last year, we will find that erosion has continued.

My third point is complex and relates to where Americans work and what I call the import and export of insurance coverage to dependents among industries. Changes in the composition of the work force, including in particular changes where Americans work, are likely to produce continuing erosion of employer-based coverage, both among workers and across the population more broadly.

In industries that are growing the fastest, employer-covered jobs are growing relatively slowly. For example, employment in professional services increased 30 percent between 1985 and 1991. Over this same period, employer-insured jobs in that industry increased by less than 20 percent.

In industries that are growing slowly or actually declining, the number of employer-insured jobs is dropping very fast. For example, while manufacturing employment dropped 5 percent between 1986 and 1991, the number of employer-insured jobs in manufacturing dropped 13 percent.

Moreover, industries in decline, in particular mining and manufacturing, are net exporters of insurance coverage to a great number of dependent

workers in other industries. In contrast, growth industries in the United States are net importers of dependents' coverage. That is, workers in growth industries are relatively likely to be covered only as the dependent of a worker in another industry.

As a result, declining employment in manufacturing by withdrawing dependents' coverage to workers in other industries is likely to depress the rate of employer coverage economy-wide.

Moreover, as health insurance costs are shifted toward workers' own industries of employment, the rate of employment growth in those industries may also decline.

In effect, declining and low-growth industries by being net exporters of dependents' coverage have subsidized total employment growth in industries that are net importers of coverage.

Finally, I would like to address the issue of Medicaid-covered workers. Medicaid is a small but a growing source of insurance coverage among workers and their families in the United States. Economy-wide, Medicaid is the only source of insurance coverage that has expanded to offset the declining rate of employer-based coverage among Americans under age 65.

Federal expansions of Medicaid eligibility to pregnant women and a growing pool of young children at income levels equal to or that exceed the poverty level have made many low-income workers and/or their dependents eligible for coverage. To resolve problems of noncoverage, many states have elected to provide Medicaid eligibility to categories of persons and to income levels that exceed federal requirements.

This pattern of greater Medicaid eligibility in lieu of employer-based coverage among low-wage workers is likely to continue as the cost of health insurance continues to rise disproportionately to wages and to the value of all of the goods produced in our economy. I believe the Committee should be aware of this dynamic between employer-based coverage and Medicaid.

I want to thank you for the opportunity to appear before you today. Again, I want to refer you to extensive tables and charts in my testimony. And I would be happy to answer any questions you have now or at any time.

[The prepared statement of Ms. Chollet starts on p.157 of Submissions for the Record:]

REPRESENTATIVE OBEY. I thank you both.

Let me ask first, Ms. Moon, your paper raises what is a very interesting point, given what the interest of this Committee has been through the years. This Committee has done a good deal of work to try and determine what has been happening to family income and to workers' wages in real terms over the past years.

Your paper said:

> Between 1965 and 1990 business spending on health care rose from 2 percent of total compensation to 7.1 percent. Thus, even if wages did not increase at all, employers' cost for compensation more than tripled in order to keep providing health insurance. Just for the period 1988 to 1991, employer-sponsored health insurance costs rose 75 percent in nominal terms as compared to an increase in average weekly earnings of 16.7 percent.

It would seem to me that in fact that statement demonstrates the direct tradeoff that workers have been experiencing at the bargaining table for years,

with health-care coverage continuation being constantly substituted for increases in direct wages.

Ms. Moon. I think that is exactly right. And it is also important to note that these rising costs are not improvements in health-care benefits in terms of expanded coverage. The higher spending is just paying for keeping in place what is already there.

Representative Obey. I think I understand what you mean, but you said under your conclusion:

> Each year families have less and less to lose from a change in the current health-care system.

Given the fact that there is bound to be a tremendous amount of nervousness, concern on the part of any family reading the stories about what may or may not happen to health care, would you just expand on that a bit and tell us why, if you were talking to a family that expressed concern about what would happen under this change, you think that there is much less risk for that family today than, say, 10 years ago.

Ms. Moon. I think sometimes it is tempting to compare proposed changes with the good old days where we knew exactly what health-care coverage was like, where there were no restrictions on use of services, and so forth. But there are very few Americans who now have such coverage

Many Americans, for example, work for employers who are increasingly putting them into managed care plans, many of which may be very good managed care plans, but the employers do not offer any choice among competing plans, for example.

When people propose to retain choice in the health-care system, it almost seems to imply that everyone has perfect choice right now. That is really not the case. Many employers already restrict substantially the choice of their employees.

One of the important things to consider when we begin to debate health-care reform is to look at exactly what it is that people have right now, and what they are likely to have in another four to five years if we don't have health-care reform. We must make sure that we are making comparisons not on the basis of some idealized system that people remember they had for a fleeting moment in 1980, but rather what they have right now and what they are likely to have in the near future.

Representative Obey. One of the witnesses yesterday, Mr. Matthews, indicated that most of the people who were not covered by insurance were persons who were unemployed, but you state in your paper that nearly three quarters of all of the insured are employed or dependents of employed persons.

So it is correct when we emphasize that the problem of the uninsured is not primarily a problem of the unemployed, that very definitely is a correct assertion, isn't it?

Ms. Moon. Definitely the employment situation is a major issue. People who lack insurance but who are employed full time are clearly a majority of the uninsured.

But even if a substantial share of the uninsured lack coverage because they are unemployed at a particular point in time, that doesn't necessarily suggest the problem is only a transition issue, because when these people get a new job, chances are, if they have a health-care problem, at best it won't be

covered for six months or nine months. At worst, insurance may not be available at all on their next job.

So, while certainly some of the uninsured may appear to be only temporarily uninsured, this is not necessarily a cause for feeling secure these days.

REPRESENTATIVE OBEY. Thank you.

Ms. Chollet, I was surprised that the number was this low and I quote:

> In 1991 just over one-half of all workers were covered directly by their employer.

MS. CHOLLET. Actually, I was wrong about that. That was among the population, not among the workers. Among workers, the ratio is about two insured directly to one dependent.

REPRESENTATIVE OBEY. All right. Thank you. I was confused by that.

MS. CHOLLET. Sorry about that.

REPRESENTATIVE OBEY. I did find your paper fascinating. I guess it states the obvious, that there are importers and exporters. I hadn't thought of it in those terms before, but this is the first time I have seen it quantified this way between various types of employment. I think you said that 30 percent of construction workers in 1991 were uninsured.

MS. CHOLLET. Yes, sir.

REPRESENTATIVE OBEY. Is there any particular reason why 1991 would be an aberrant year, because of the economy, or is that a pretty normal situation?

MS. CHOLLET. No, sir, it has been going upward for a long period of time. It seems to me, in industries that have very high job turnover, both in terms of workers coming and going from particular jobs and in terms of firms that fail and are replaced by new firms, in those industries, it is not a matter of cutting back on existing benefits and having workers pay more. It is firms going out of business that offer insurance coverage and firms finding they can start up and compete and not offer insurance coverage. So, in industries that have very high rates of firm failure, you will find very fast declines in employer-based coverage.

REPRESENTATIVE OBEY. You also assert, and I have heard the opposite asserted by some people, but you describe changes in the working pattern, or in the pattern of coverage and number of workers covered by employer-provided insurance, fell during the 1980s and that the pattern is not due to the business cycle.

Would you expand on that and tell us why you think there is clear evidence that that is not simply due to the business cycle?

MS. CHOLLET. I find this a very troubling dynamic, but it is an enduring one that we have seen over the past 10 years, and I see no reason to expect this dynamic not to continue. Firms that fail during a recession, find that they can start up again inexpensively, or new firms can form relatively inexpensively during periods of intense competition, if they cut their costs. And one way for a firm to cut its costs is not to offer an insurance plan.

If a firm is bidding in particular for low wage and relatively unskilled workers, the cost of a health insurance plan is disproportionate to the economic value of that worker. Thus, the vast majority of workers who are covered as a dependent are very low-wage workers. When those workers lose that coverage from any source, they don't get it back. They are not in an economic

position to bid for the level of compensation that is implicit in receiving a health insurance plan.

As our economy becomes more mobile, as workers move among jobs, and as we move towards smaller firms and large firms are downsized, we are likely to see more of this churning in the workplace going on. At one level, it is competitively efficient. However, the dynamic is that I can compete as a firm if I keep my costs very, very low. One obvious way to keep them low is to cut insurance.

REPRESENTATIVE OBEY. Especially if health-care costs are rising at a rapid rate.

MS. CHOLLET. Especially, that is the factor that feeds the dynamic, yes.

REPRESENTATIVE OBEY. All right. Well, I have more questions, but I don't have more time.

REPRESENTATIVE OBEY. I thank you both for coming. I appreciate it.

I thank all the witnesses who came this morning.

[Whereupon, at 11:50 a.m., the Committee adjourned, subject to the call of the Chair.]

SUBMISSIONS FOR THE RECORD

WRITTEN OPENING STATEMENT OF REPRESENTATIVE RAMSTAD

Mr. Chairman, as I stated yesterday and want to reiterate today, I applaud you for holding this important hearing on one of the most critical issues facing the workers, families and businesses of our nation.

I certainly hope you will continue to hold hearings like this as we begin in earnest to consider health care reform legislation.

I must again register my deep disappointment that Dr. Laura Tyson, the chair of President Clinton's Council of Economic Advisors, who had been scheduled to participate in this two- day hearing series, did not appear before the Committee yesterday.

I was equally disappointed the JEC did not hold a single hearing on President Clinton's tax bill in the five and a half months from the time he announced his plan in February to the time Congress narrowly passed the measure in August.

I strongly urge the chairman to avoid using the same strategy during the health care debate. Of all committees, the JEC can be a key facilitator of the discussion on this important issue.

I must also say I am deeply concerned about those details of the Administration's proposal that I've seen. The Administration's plan will require all small employers to pay 80% of the premiums of their employees health insurance. These premiums—essentially a hidden tax—could literally drive small businesses out of business and destroy hundreds of thousands of jobs.

The ability of large companies with over 5000 employees to opt out of this system makes the employer mandate-based system even more onerous for the small business owner.

That's because the uninsured, Medicare and workers' compensation costs all will be rolled into the employer mandated system. As the Fortune 500s opt out, small businesses will end up footing the bill for their own employees, the uninsured, Medicare recipients and worker's compensation—all through their premium payments!

A recent study of the economic impact of the Clinton Administration's proposed mandate on employers said the mandates will lead to the loss of 3.1 million jobs nationwide. The study was conducted by professors June and Dave O'Neill, both highly respected labor economists from Baruch College.

Last year we heard the Democrat leadership talk about a "Play or Pay" plan under which employers either had to cover their employees or pay steep penalties. The Clinton plan should be called "Play AND Pay."

Regardless of how efficiently employers can cover their workers' insurance costs, they will be forced to buy coverage from a monopoly "regional health alliance" and pay government-determined premium prices. This will drive costs up and reduce the quality of care available to workers.

If small companies go out of business or lay off workers because they can't afford the premiums, more individuals will fall into the "uninsured" category. This means the remaining small businesses will face even higher premiums because they are expected to cover the uninsured. As costs rise higher, more businesses will lay off workers or shut down. Premium costs will skyrocket and literally bankrupt our economy.

We all know that without a thriving small business sector, our economy will never grow. That's why I was absolutely astounded when, during a health care briefing before the Small Business Committee, Hillary Rodham Clinton responded to a question from one of my Democrat colleagues who expressed concern about the impact of the plan on small business by saying, "I can't go out and save every undercapitalized entrepreneur in America."

This cavalier disregard for jobs and the small businesses in our country is shocking. We will never be able to expand health care coverage to the millions of uninsured Americans if the plan kills the small business sector of our economy.

Mr. Chairman, I am also extremely concerned about the absence of significant cost containment provisions in the Administration's proposal. Two glaring contributors to rising health care costs—burdensome state mandates and skyrocketing administrative costs—were not addressed by the Task Force.

Under the Task Force plan, administrative costs will rise even more and the source of expensive mandates will simply shift from the state government to the federal government.

Mr. Chairman, we need a comprehensive cost containment strategy that includes reforming the medical malpractice system to eliminate the need for expensive "defensive medicine;" streamlining unnecessary administrative costs; and preempting burdensome state mandates on health insurance, which add unnecessary costs to all health insurance policies.

Again, I thank you for holding this hearing. I look forward to working with my colleagues to address the astronomical rise in health care costs in a way that preserves consumer choice and protects the vital small business sector of our economy.

PREPARED STATEMENT OF RONALD F. POLLACK

Mr. Chairman and Members of the Committee:

Good morning. Thank you for inviting me to testify before you today. Families USA Foundation is a national nonprofit organization that represents consumers on health and long term care issues. We are ardent supporters of comprehensive health care reform. We believe that the current crisis state of our health care system can and must be fixed.

The goal of health care reform must be to assure every person in America that he or she will never lose his or her health insurance, no matter what! There are many interests that are working against that goal. Under our current system, insurance companies follow their own rules which deny coverage to anyone who is or might become sick. All of us are in jeopardy of losing our health insurance. Soon we will be issuing a report that shows that every month more than two million people lose their health insurance. While most of them gain coverage in the future, they are all at risk and indeed some never regain their coverage and others will be subject to limitations on coverage for pre-existing conditions.

The other major threat to coverage for Americans is cost, the subject of today's hearing. It is no secret that Americans are charged more for healthcare than people in every other country in the world. We are rapidly approaching the time when only healthy people will be offered coverage and only the wealthiest will be able to afford it.

You have asked me to focus my testimony on the threat of health care costs to the family budget. In 1991 we issued a study entitled *Health Spending: The Growing Threat to the Family Budget.* This report examined, for the first time, the total impact of health care spending on American families and businesses, nationally and state-by-state, for the years 1980,1991 and 2000. We looked at direct and indirect health expenditures to produce a comprehensive picture of health care spending by families and businesses.

We are currently in the process of updating the results of this study and will release the findings in the next couple of months. While I do not have all the results, I can tell you that, based on preliminary findings, families are and will be bearing even more of the costs of the health care crisis than we initially predicted.

Let me add one important caveat about the estimates I will give you. They understate the burden of health care costs on families since there is no attempt to determine how much of business's health expenditures are simply passed back to individuals through lower wages, higher prices, or reduced payments to shareholders. These estimates also do not attempt to account for the cost to individuals of the business tax deduction for health benefit expenses.

Our key findings as of 1991:

- In 1991, the U.S. spent an average of $6,535 on health care per family. By the year 2000, we will be spending $13,911 per family.
- In 1980, the average family spent $1 out of every $11 of its income to support our health care system. By the year 2000, the average family will spend $1 on health care for every $6 of income.
- In 1980, American families paid on average a total of $1,742 for health care. This amount includes out-of-pocket expenses, health insurance, state and federal taxes that are spent on health care. In 1990, that figure rose to $4,296, a two and one-half-fold increase. By the year 2000, the average health payment by families is expected to rise to $9,397, more than five times the amount in 1980.
- The family bears most of health care costs in America by Paying over 65 percent of the bill. America's businesses pick up the rest of the tab, which is less than 35 percent. Aggregate health spending by families rose from $155.5 billion in 1980 to $456. 1 billion in 1991, and is expected to rise to almost $1. 1 trillion by the year 2000, an almost six-fold increase over two decades.

This study includes the same information on a state-by-state basis. For example, in your home state of Wisconsin, Mr. Chairman, total health spending per family was $6,651 in 1991, slighfly higher than the national average. I have attached the charts from our 1991 report so you can see all the information on a state-by-state basis.

The Impact of Soaring Health Costs on Families

We found that American families are paying the vast majority of unbridled health costs. The magnitude of this burden often goes unrecognized, since families pay for health care out of many pockets and employers pay only for health insurance premiums. Almost two-thirds of health costs in 1991 were paid by families. In some states, families are paying over 70 percent of total health care services.

It is remarkable to see how families are footing the bill. The lion's share of family health care spending is being financed through general taxes and out-of-pocket expenses. The two resources together comprise 72 percent of family health care spending. Private health insurance and Medicare premiums make up 20 percent of family health spending.

Families are also having to take on additional costs related to employer-provided health benefits. In 1980, employees paid 18 percent of the cost of employer-sponsored health insurance. By 1991, that percentage had increased to 23 percent. If this trend continues over the next decade, the employee share will increase to 26 percent. For families, this is a twofold burden. They will not only be paying an increasing percentage of insurance premiums but the size of those premiums will rise at more than twice the rate of inflation.

Family incomes have suffered since 1980 as health care costs have increased. The average family income increased 88 percent from 1980 to 1991, while average family spending for health care has increased 147 percent. In other words, in 1980, average family health spending amounted to 9 percent of average family income. By 1991, average family health spending amounted to almost 12 percent of average family income, a 30-percent increase. If current trends continue, average family health spending would consume 16.4 percent of average family income by the year 2000.

The Impact on Business

Businesses pay the other one-third of our nation's health care bill. More significantly, businesses pay the preponderance of health insurance costs in this country—67% of all private insurance costs in 1991. Over half of business spending on health care goes directly for insurance. Since health insurance increases averaged in the double digits over the last decade, insurance costs have become a greater and greater financial liability for business. Business payments for health insurance were more than three times higher in 1991 than in 1980.

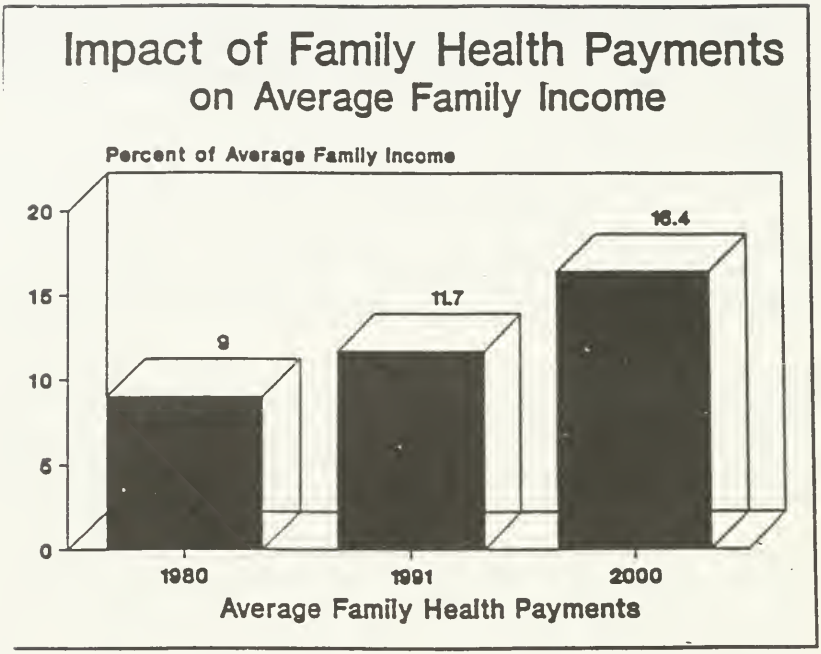
In addition to health insurance costs, businesses pay significant amounts for health care through corporate taxes and through the Medicare payroll tax. General taxes paid by businesses for health care increased 267 percent from 1980 to 1991, and business payments of Medicare payroll taxes increased 234 percent.

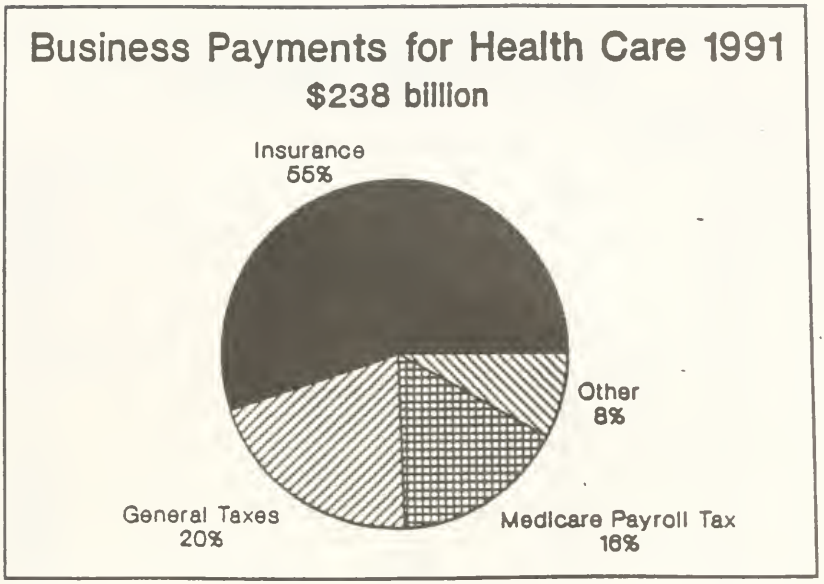
In fact, in 1989, businesses spent the same amount on health premiums, Medicare payroll taxes, workers' compensation, temporary disability and employee health programs as they made in after-tax profits. By contrast, in 1980, business health care spending equalled 44% of corporations' after-tax profits. This indicates the magnitude of the liability health spending has become for American businesses.

The liability for business is also a liability for American workers. Business health spending, excluding general taxes, increased for private sector workers from 5. 1 % of total compensation in 1980 to 7% in 1989. The increasing amount of employer resources consumed by health benefits has meant that these employer resources have not been available for wage increases or to help workers with other benefits.

The Dwindling Family Health Account

Americans simply cannot afford the prices they are charged for health coverage. As a country we can no longer afford to keep Americans guessing about whether health care will be there when they need it. We must enact comprehensive health care reform that will guarantee that families will never lose their health insurance, no matter what.


Impact of Family Health Payments
on Average Family Income
Percent of Average Family Income
20
15
10
5
0
9
11.7
16.4
1980
1991
2000
Average Family Health Payments


Business Payments for Health Care 1991
$238 billion
Insurance
55%
Other
8%
Medicare Payroll Tax
16%
General Taxes
20%

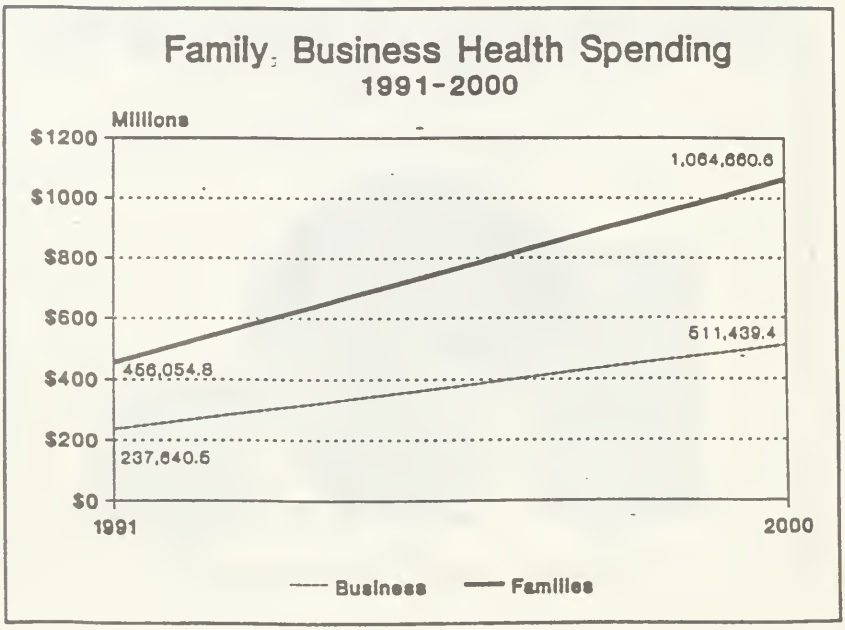

Family, Business Health Spending
1991-2000
Millions
$1200
$1000
$800
$600
$400
$200
$0
1,064,660.6
511,439.4
456,054.8
237,640.5
1991
2000
Business
Families

TABLE 1

FAMILY* AND BUSINESS SPENDING FOR HEALTH CARE** 1991

State	State Rank in Average Health Payments by Families	Average Health Payments by Families	Average Business Health Payments Per Family	Total Health Spending Per Family (paid by both sources)
TOTAL		$4,288	$2,230	$6,535
ALABAMA	24	$4,064	$1,541	$5,604
ALASKA	34	$3,848	$3,810	$7,758
ARIZONA	45	$3,438	$1,882	$5,321
ARKANSAS	42	$3,480	$1,301	$4,781
CALIFORNIA	13	$4,435	$2,706	$7,141
COLORADO	28	$3,933	$2,141	$6,073
CONNECTICUT	2	$5,421	$3,890	$9,312
DELAWARE	14	$4,393	$2,181	$6,573
DISTRICT OF COLUMBIA	17	$4,300	$1,754	$6,054
FLORIDA	29	$3,932	$1,623	$5,556
GEORGIA	22	$4,159	$1,633	$5,792
HAWAII	7	$4,596	$2,594	$7,190
IDAHO	51	$3,005	$1,594	$4,599
ILLINOIS	8	$4,670	$2,700	$7,370
INDIANA	26	$3,972	$1,657	$5,630
IOWA	25	$4,028	$2,122	$6,148
KANSAS	11	$4,461	$2,477	$6,938
KENTUCKY	46	$3,208	$1,329	$4,535
LOUISIANA	35	$3,809	$1,868	$5,677
MAINE	27	$3,945	$2,322	$6,266
MARYLAND	10	$4,464	$1,697	$6,161
MASSACHUSETTS	3	$5,321	$3,164	$8,484
MICHIGAN	6	$4,569	$2,766	$7,337
MINNESOTA	9	$4,586	$2,664	$7,252
MISSISSIPPI	50	$3,009	$1,146	$4,156
MISSOURI	15	$4,362	$2,353	$6,716
MONTANA	49	$3,154	$1,755	$4,910
NEBRASKA	18	$4,288	$2,288	$6,554
NEVADA	31	$3,887	$2,393	$6,280
NEW HAMPSHIRE	33	$3,880	$2,701	$6,581
NEW JERSEY	5	$4,883	$2,722	$7,606
NEW MEXICO	47	$3,297	$1,518	$4,815
NEW YORK	1	$5,565	$2,625	$8,210
NORTH CAROLINA	40	$3,630	$1,471	$5,101
NORTH DAKOTA	21	$4,193	$2,335	$6,529
OHIO	12	$4,474	$2,531	$7,005
OKLAHOMA	36	$3,786	$1,393	$5,179
OREGON	30	$3,900	$2,145	$6,045
PENNSYLVANIA	16	$4,300	$2,524	$6,825
RHODE ISLAND	4	$4,914	$2,733	$7,647
SOUTH CAROLINA	48	$3,414	$1,308	$4,722
SOUTH DAKOTA	32	$3,883	$2,056	$5,919
TENNESSEE	41	$3,487	$2,152	$5,639
TEXAS	23	$4,095	$1,798	$5,881
UTAH	38	$3,682	$2,017	$5,699
VERMONT	39	$3,649	$1,649	$5,598
VIRGINIA	18	$4,358	$1,647	$5,606
WASHINGTON	37	$3,710	$2,117	$5,826
WEST VIRGINIA	44	$3,443	$1,653	$5,096
WISCONSIN	20	$4,245	$2,406	$6,651
WYOMING	43	$3,474	$1,810	$5,284

* Families are groups of one or more persons related by birth, marriage, or adoption and who are residing together. Parents and adult children residing with other family members were counted as separate units

**Health payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

TABLE 2

AVERAGE HEALTH PAYMENTS* BY FAMILIES**

STATE	1980	1991	2000	% Increase 1980 - 1991	% Increase 1980 - 2000
TOTAL	$1,742	$4,298	$9,387	147%	439%
ALABAMA	$1,707	$4,084	$8,893	139%	421%
ALASKA	$1,590	$3,848	$7,290	142%	357%
ARIZONA	$1,306	$3,439	$7,222	163%	452%
ARKANSAS	$1,444	$3,480	$7,378	141%	425%
CALIFORNIA	$1,888	$4,433	$8,785	135%	466%
COLORADO	$1,858	$3,933	$8,588	117%	418%
CONNECTICUT	$2,015	$5,421	$12,100	169%	501%
DELAWARE	$1,913	$4,393	$9,055	130%	373%
DISTRICT OF COLUMBIA	$1,878	$4,300	$9,445	157%	484%
FLORIDA	$1,483	$3,932	$8,235	165%	483%
GEORGIA	$1,888	$4,159	$8,884	150%	433%
HAWAII	$1,829	$4,586	$8,986	151%	446%
IDAHO	$1,202	$3,005	$6,728	150%	459%
ILLINOIS	$2,002	$4,670	$10,423	133%	421%
INDIANA	$1,943	$3,972	$8,770	142%	434%
IOWA	$1,828	$4,028	$8,021	121%	364%
KANSAS	$1,801	$4,481	$8,837	149%	446%
KENTUCKY	$1,324	$3,208	$7,177	110%	371%
LOUISIANA	$1,871	$3,809	$8,511	128%	408%
MAINE	$1,467	$3,948	$8,640	169%	481%
MARYLAND	$2,049	$4,484	$9,878	119%	382%
MASSACHUSETTS	$2,062	$5,321	$11,934	158%	479%
MICHIGAN	$1,879	$4,589	$10,054	143%	435%
MINNESOTA	$1,920	$4,586	$9,884	139%	414%
MISSISSIPPI	$1,303	$3,009	$6,598	131%	406%
MISSOURI	$1,743	$4,362	$9,426	150%	441%
MONTANA	$1,345	$3,134	$7,150	135%	432%
NEBRASKA	$1,804	$4,286	$9,348	137%	418%
NEVADA	$1,611	$3,897	$8,394	158%	436%
NEW HAMPSHIRE	$1,390	$3,880	$8,050	178%	479%
NEW JERSEY	$1,940	$4,883	$10,752	181%	454%
NEW MEXICO	$1,209	$3,297	$7,109	173%	486%
NEW YORK	$2,159	$5,085	$12,890	169%	486%
NORTH CAROLINA	$1,621	$3,830	$7,784	139%	413%
NORTH DAKOTA	$1,795	$4,193	$9,228	134%	414%
OHIO	$1,845	$4,474	$9,699	142%	437%
OKLAHOMA	$1,814	$3,766	$8,384	134%	416%
OREGON	$1,418	$3,900	$8,772	175%	619%
PENNSYLVANIA	$1,749	$4,300	$9,571	146%	447%
RHODE ISLAND	$1,900	$4,914	$10,882	159%	472%
SOUTH CAROLINA	$1,376	$3,414	$7,474	148%	443%
SOUTH DAKOTA	$1,832	$3,883	$8,395	137%	413%
TENNESSEE	$1,473	$3,497	$7,401	137%	402%
TEXAS	$1,794	$4,095	$8,769	128%	390%
UTAH	$1,441	$3,682	$8,184	155%	468%
VERMONT	$1,329	$3,648	$7,974	175%	500%
VIRGINIA	$1,883	$4,358	$9,831	182%	476%
WASHINGTON	$1,489	$3,710	$8,381	149%	462%
WEST VIRGINIA	$1,592	$3,443	$7,709	116%	384%
WISCONSIN	$1,801	$4,245	$9,337	136%	419%
WYOMING	$1,383	$3,474	$7,945	151%	474%

* Health payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

** Families are groups of one or more persons related by birth, marriage, or adoption and who are residing together. Parents and adult children residing

TABLE 3

IMPACT OF HEALTH PAYMENTS* ON AVERAGE FAMILY** INCOME

STATE	1980			1981		
	Average Family Income	Average Health Payments by Families	%	Average Family Income	Average Health Payments by Families	%
TOTAL	$19 458	$1 742	9 0%	$38 848	$4 298	11 7%
ALABAMA	$18 277	$1 707	10 5%	$29 007	$4 084	14 0%
ALASKA	$25 591	$1 590	8 2%	$42 558	$3 848	9 0%
ARIZONA	$18 788	$1 308	7 0%	$34 832	$3 430	9 8%
ARKANSAS	$15 181	$1 444	8 5%	$28 301	$3 480	12 3%
CALIFORNIA	$20 524	$1 888	8 1%	$39 874	$4 433	11 1%
COLORADO	$21 348	$1 658	7 8%	$35 021	$3 833	11 2%
CONNECTICUT	$21 704	$2 015	9 3%	$48 908	$5 421	10 8%
DELAWARE	$20 817	$1 913	9 2%	$35 840	$4 383	12 3%
DISTRICT OF COLUMBIA	$17 065	$1 678	9 8%	$34 125	$4 100	12 8%
FLORIDA	$16 723	$1 413	8 7%	$33 138	$3 832	11 8%
GEORGIA	$18 848	$1 668	8 5%	$35 898	$4 159	11 7%
HAWAII	$22 281	$1 829	8 2%	$45 837	$4 588	10 0%
IDAHO	$18 580	$1 202	7 3%	$30 724	$3 005	9 8%
ILLINOIS	$21 681	$2 002	9 2%	$36 788	$4 870	12 0%
INDIANA	$17 455	$1 643	9 4%	$32 018	$3 972	12 4%
IOWA	$18 408	$1 626	9 4%	$31 890	$4 026	12 7%
KANSAS	$19 357	$1 801	9 3%	$35 272	$4 481	12 7%
KENTUCKY	$17 873	$1 524	8 8%	$28 528	$3 208	10 8%
LOUISIANA	$17 881	$1 671	9 5%	$30 288	$3 809	12 8%
MAINE	$18 806	$1 487	9 0%	$35 752	$3 948	11 0%
MARYLAND	$23 958	$2 049	8 6%	$41 883	$4 484	10 8%
MASSACHUSETTS	$20 598	$2 062	10 0%	$43 401	$5 321	12 3%
MICHIGAN	$20 029	$1 878	9 4%	$37 058	$4 588	12 3%
MINNESOTA	$18 172	$1 820	10 0%	$38 242	$4 588	12 8%
MISSISSIPPI	$15 070	$1 303	8 6%	$27 814	$3 008	10 8%
MISSOURI	$17 920	$1 743	9 7%	$34 027	$4 362	12 8%
MONTANA	$18 025	$1 345	7 5%	$28 269	$3 154	10 8%
NEBRASKA	$17 884	$1 804	10 1%	$32 980	$4 288	12 9%
NEVADA	$18 778	$1 511	7 8%	$33 487	$3 887	11 8%
NEW HAMPSHIRE	$20 269	$1 390	8 9%	$35 384	$3 860	10 9%
NEW JERSEY	$22 209	$1 840	8 7%	$47,150	$4 883	10 3%
NEW MEXICO	$17 832	$1 209	8 8%	$32,127	$3 297	10 3%
NEW YORK	$18 206	$2 158	11 2%	$40,204	$5 585	13 9%
NORTH CAROLINA	$18 388	$1 521	8 3%	$33,081	$3 830	11 0%
NORTH DAKOTA	$17 428	$1 765	10 5%	$29 702	$4,103	14 1%
OHIO	$20 101	$1 845	9 2%	$36,051	$4 474	12 4%
OKLAHOMA	$18 300	$1 614	8 8%	$32,783	$3 788	11 5%
OREGON	$18 832	$1 418	7 5%	$34,152	$3 900	11 4%
PENNSYLVANIA	$18 181	$1 749	9 1%	$37,045	$4 300	11 6%
RHODE ISLAND	$18 458	$1 900	10 3%	$37,888	$4 914	13 0%
SOUTH CAROLINA	$18 123	$1 378	8 5%	$33,140	$3,414	10 3%
SOUTH DAKOTA	$18 278	$1 832	10 0%	$29 467	$3 883	13 1%
TENNESSEE	$18 819	$1 473	8 8%	$30 900	$3 487	11 3%
TEXAS	$18 421	$1 784	9 2%	$33,737	$4 085	12 1%
UTAH	$20,048	$1 441	7 2%	$36 258	$3 682	10 2%
VERMONT	$17 183	$1 329	7 7%	$37,284	$3 849	9 6%
VIRGINIA	$19 898	$1 885	9 4%	$42 518	$4 358	10 3%
WASHINGTON	$19 341	$1 488	7 7%	$37,086	$3,710	10 0%
WEST VIRGINIA	$18 177	$1 582	9 8%	$28 081	$3,443	12 3%
WISCONSIN	$18 850	$1 801	9 2%	$34 839	$4 245	12 2%
WYOMING	$20 217	$1 365	9 8%	$33,038	$3,474	8 7%

* Health payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets It also includes government public health expenditures the administrative costs of public programs and the net cost of private insurance We have excluded from this presentation non patient revenue research and construction

** Families are groups of one or more persons related by birth, marriage or adoption and who are residing together Parents and adult children residing with other family members were counted as separate units

TABLE 4A

HOW FAMILIES* PAID FOR HEALTH CARE** 1980

STATE	TOTAL FAMILY		OUT-OF-POCKET		INSURANCE		MEDICARE PAYROLL TAX		MEDICARE PREMIUMS		GENERAL TAXES***	
	Per Family	%	Per Family	%	Per Family	%	Per Family	%	Per Family	%	Per Family	%
TOTAL	$1,742	100.0%	$654	37.6%	$259	14.9%	$132	7.6%	$34	1.9%	$664	38.1%
ALABAMA	$1,707	100.0%	$739	43.3%	$212	12.4%	$108	6.2%	$37	2.2%	$612	35.9%
ALASKA	$1,590	100.0%	$538	33.8%	$178	11.2%	$57	3.6%	$8	0.5%	$808	50.8%
ARIZONA	$1,308	100.0%	$481	35.4%	$180	12.2%	$103	7.9%	$30	2.3%	$552	42.2%
ARKANSAS	$1,444	100.0%	$622	43.0%	$168	11.5%	$98	6.8%	$43	3.0%	$518	35.7%
CALIFORNIA	$1,990	100.0%	$749	33.8%	$187	11.2%	$125	7.5%	$28	1.7%	$787	48.1%
COLORADO	$1,658	100.0%	$547	33.0%	$184	11.7%	$124	7.5%	$24	1.5%	$789	48.4%
CONNECTICUT	$2,015	100.0%	$773	38.4%	$351	17.4%	$181	9.0%	$35	1.7%	$895	34.5%
DELAWARE	$1,913	100.0%	$689	36.0%	$220	11.5%	$180	9.4%	$32	1.7%	$792	41.4%
DISTRICT OF COLUMBIA	$1,878	100.0%	$484	25.5%	$150	8.0%	$204	12.2%	$25	1.5%	$802	47.9%
FLORIDA	$1,453	100.0%	$597	40.6%	$172	11.7%	$92	6.3%	$43	2.9%	$550	38.2%
GEORGIA	$1,668	100.0%	$687	41.2%	$203	12.2%	$115	6.9%	$31	1.9%	$629	37.8%
HAWAII	$1,829	100.0%	$575	31.5%	$200	10.9%	$128	7.0%	$29	1.6%	$801	43.8%
IDAHO	$1,202	100.0%	$399	33.2%	$137	11.4%	$118	9.9%	$31	2.5%	$517	43.0%
ILLINOIS	$2,002	100.0%	$736	36.8%	$365	18.2%	$161	8.0%	$34	1.7%	$708	35.3%
INDIANA	$1,643	100.0%	$631	38.4%	$315	19.1%	$131	8.0%	$32	1.9%	$535	32.6%
IOWA	$1,826	100.0%	$683	37.4%	$351	19.3%	$128	7.0%	$41	2.2%	$622	34.1%
KANSAS	$1,801	100.0%	$672	37.3%	$351	19.5%	$124	6.9%	$38	2.1%	$615	34.2%
KENTUCKY	$1,524	100.0%	$657	43.1%	$207	13.6%	$99	6.5%	$38	2.5%	$524	34.3%
LOUISIANA	$1,871	100.0%	$695	41.6%	$208	12.5%	$118	6.9%	$29	1.7%	$822	37.2%
MAINE	$1,487	100.0%	$618	41.5%	$281	18.9%	$85	5.4%	$40	2.7%	$453	30.5%
MARYLAND	$2,048	100.0%	$769	37.5%	$253	12.3%	$132	6.5%	$29	1.4%	$867	42.3%
MASSACHUSETTS	$2,062	100.0%	$600	36.8%	$345	18.2%	$135	6.5%	$37	1.8%	$749	36.3%
MICHIGAN	$1,878	100.0%	$689	36.6%	$352	18.8%	$183	9.7%	$31	1.7%	$644	34.3%
MINNESOTA	$1,920	100.0%	$712	37.1%	$366	19.1%	$158	8.3%	$35	1.8%	$648	33.8%
MISSISSIPPI	$1,303	100.0%	$635	48.6%	$77	5.9%	$85	6.5%	$39	3.0%	$468	35.8%
MISSOURI	$1,743	100.0%	$696	39.8%	$348	20.0%	$129	7.4%	$39	2.2%	$530	30.4%
MONTANA	$1,345	100.0%	$481	34.3%	$153	11.4%	$103	7.7%	$32	2.4%	$586	44.3%
NEBRASKA	$1,804	100.0%	$708	39.2%	$351	19.4%	$127	7.1%	$39	2.1%	$581	32.2%
NEVADA	$1,511	100.0%	$507	33.5%	$177	11.7%	$102	6.8%	$21	1.4%	$704	46.6%
NEW HAMPSHIRE	$1,390	100.0%	$583	40.5%	$253	18.2%	$118	8.3%	$32	2.3%	$425	30.6%
NEW JERSEY	$1,940	100.0%	$664	34.2%	$313	18.1%	$157	9.1%	$39	2.0%	$768	39.6%
NEW MEXICO	$1,208	100.0%	$430	35.5%	$133	11.0%	$103	8.5%	$28	2.3%	$515	42.8%
NEW YORK	$2,159	100.0%	$740	34.3%	$326	15.1%	$175	8.1%	$37	1.7%	$881	40.8%
NORTH CAROLINA	$1,521	100.0%	$609	40.1%	$182	12.0%	$118	7.8%	$33	2.2%	$578	38.0%
NORTH DAKOTA	$1,795	100.0%	$735	41.0%	$375	20.9%	$113	6.3%	$36	2.1%	$533	29.7%
OHIO	$1,845	100.0%	$718	38.8%	$378	20.5%	$147	8.0%	$34	1.8%	$571	31.0%
OKLAHOMA	$1,814	100.0%	$632	39.1%	$188	11.5%	$117	7.2%	$33	2.2%	$644	39.9%
OREGON	$1,418	100.0%	$455	32.1%	$161	11.4%	$116	8.3%	$31	2.2%	$652	46.0%
PENNSYLVANIA	$1,748	100.0%	$696	38.8%	$318	18.2%	$136	7.8%	$39	2.2%	$556	31.8%
RHODE ISLAND	$1,900	100.0%	$732	38.5%	$348	18.3%	$132	7.0%	$41	2.1%	$648	34.1%
SOUTH CAROLINA	$1,378	100.0%	$526	38.2%	$140	10.2%	$108	7.7%	$30	2.2%	$574	41.7%
SOUTH DAKOTA	$1,832	100.0%	$712	43.8%	$337	20.6%	$105	6.4%	$40	2.5%	$438	26.9%
TENNESSEE	$1,473	100.0%	$727	49.3%	$221	15.0%	$123	8.4%	$36	2.4%	$367	24.8%
TEXAS	$1,794	100.0%	$710	39.8%	$201	11.2%	$133	7.4%	$28	1.8%	$722	40.2%
UTAH	$1,441	100.0%	$478	33.2%	$169	11.7%	$98	6.8%	$24	1.7%	$671	46.6%
VERMONT	$1,329	100.0%	$522	39.3%	$237	17.8%	$98	7.4%	$33	2.5%	$440	33.1%
VIRGINIA	$1,685	100.0%	$606	36.5%	$192	11.5%	$103	6.2%	$28	1.7%	$734	44.1%
WASHINGTON	$1,469	100.0%	$442	29.7%	$154	10.3%	$113	7.6%	$26	1.8%	$751	50.5%
WEST VIRGINIA	$1,592	100.0%	$696	43.7%	$208	13.0%	$102	6.4%	$41	2.5%	$547	34.4%
WISCONSIN	$1,801	100.0%	$672	37.3%	$339	19.9%	$142	7.9%	$36	2.0%	$592	32.9%
WYOMING	$1,385	100.0%	$374	27.0%	$136	9.8%	$104	7.5%	$23	1.6%	$748	54.0%

* Families are groups of one or more persons related by birth, marriage, or adoption and who are residing together. Parents and adult children residing with other family members were counted as separate units.

** Health care payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

***General taxes include federal contributions to Medicare, the federal and state components of Medicaid, federal and state government contributions to employer sponsored insurance, and funding for other federal and state public programs. Other public programs include public and general and general assistance, Maternal and Child Health, Vocational Rehabilitation, and other public activities.

HOW FAMILIES* PAY FOR HEALTH CARE** 1991

STATE	TOTAL FAMILY		OUT-OF POCKET		INSURANCE		MEDICARE PAYROLL TAX		MEDICARE PREMIUMS		GENERAL TAXES***	
	Per Family	%	Per Family	%	Per Family	%	Per Family	%	Per Family	%	Per Family	%
TOTAL	$4,796	100.0%	$1,362	31.7%	$738	17.2%	$388	8.6%	$112	2.6%	$1,713	39.9%
ALABAMA	$4,084	100.0%	$1,503	37.0%	$627	15.4%	$274	8.6%	$118	2.9%	$1,541	37.9%
ALASKA	$3,848	100.0%	$1,348	35.1%	$699	18.2%	$548	14.2%	$38	1.0%	$1,214	31.6%
ARIZONA	$3,419	100.0%	$1,106	32.2%	$556	16.2%	$281	8.2%	$112	3.3%	$1,364	40.3%
ARKANSAS	$3,480	100.0%	$1,264	36.8%	$474	13.8%	$310	8.8%	$133	3.8%	$1,278	36.8%
CALIFORNIA	$4,433	100.0%	$1,406	31.7%	$732	16.5%	$358	8.0%	$90	2.0%	$1,848	41.7%
COLORADO	$3,933	100.0%	$1,223	31.1%	$673	17.1%	$312	7.9%	$82	2.1%	$1,643	41.8%
CONNECTICUT	$5,421	100.0%	$1,486	27.4%	$1,012	18.7%	$567	10.5%	$124	2.3%	$2,230	41.1%
DELAWARE	$4,393	100.0%	$1,329	30.3%	$588	13.4%	$708	16.1%	$102	2.3%	$1,664	37.9%
DISTRICT OF COLUMBIA	$4,300	100.0%	$924	21.5%	$360	8.4%	$901	21.0%	$85	2.0%	$2,030	47.2%
FLORIDA	$3,932	100.0%	$1,412	36.4%	$553	14.1%	$260	6.6%	$148	3.7%	$1,541	39.2%
GEORGIA	$4,158	100.0%	$1,327	31.8%	$558	13.4%	$340	8.2%	$93	2.2%	$1,843	44.3%
HAWAII	$4,598	100.0%	$1,378	30.0%	$757	16.5%	$341	7.4%	$100	2.2%	$2,020	43.9%
IDAHO	$3,005	100.0%	$845	31.5%	$497	16.5%	$277	8.2%	$114	3.8%	$1,172	39.0%
ILLINOIS	$4,870	100.0%	$1,496	32.0%	$997	21.4%	$421	8.0%	$111	2.4%	$1,844	38.2%
INDIANA	$3,872	100.0%	$1,258	31.7%	$850	21.4%	$325	8.2%	$112	2.8%	$1,427	35.9%
IOWA	$4,026	100.0%	$1,332	33.1%	$934	23.2%	$320	7.9%	$136	3.4%	$1,305	32.4%
KANSAS	$4,481	100.0%	$1,496	33.5%	$1,031	23.0%	$340	7.6%	$125	2.8%	$1,488	33.2%
KENTUCKY	$3,206	100.0%	$1,089	34.3%	$443	13.8%	$240	7.5%	$114	3.6%	$1,310	40.8%
LOUISIANA	$3,809	100.0%	$1,326	34.8%	$537	14.1%	$290	7.6%	$104	2.7%	$1,551	40.7%
MAINE	$3,948	100.0%	$1,218	30.8%	$813	20.6%	$268	6.8%	$128	3.2%	$1,520	38.5%
MARYLAND	$4,484	100.0%	$1,333	29.7%	$591	13.2%	$373	8.3%	$90	2.0%	$2,097	46.8%
MASSACHUSETTS	$5,321	100.0%	$1,528	28.7%	$950	17.8%	$448	8.4%	$117	2.2%	$2,276	42.8%
MICHIGAN	$4,569	100.0%	$1,420	31.1%	$1,014	22.2%	$481	10.1%	$113	2.5%	$1,581	34.2%
MINNESOTA	$4,568	100.0%	$1,415	31.0%	$968	21.2%	$427	9.3%	$112	2.4%	$1,848	38.0%
MISSISSIPPI	$3,009	100.0%	$1,104	36.7%	$408	13.6%	$208	6.9%	$114	3.8%	$1,173	38.0%
MISSOURI	$4,362	100.0%	$1,482	34.0%	$987	22.6%	$385	8.4%	$126	2.9%	$1,402	32.1%
MONTANA	$3,154	100.0%	$978	30.9%	$483	15.3%	$248	7.8%	$118	3.7%	$1,329	42.1%
NEBRASKA	$4,268	100.0%	$1,456	34.2%	$989	23.2%	$353	8.3%	$125	2.9%	$1,344	31.5%
NEVADA	$3,897	100.0%	$1,303	33.4%	$689	17.7%	$252	6.5%	$89	2.3%	$1,584	40.1%
NEW HAMPSHIRE	$3,860	100.0%	$1,282	33.2%	$704	18.2%	$362	9.4%	$103	2.7%	$1,408	36.5%
NEW JERSEY	$4,863	100.0%	$1,261	25.9%	$798	13.8%	$506	10.4%	$122	2.5%	$2,207	45.4%
NEW MEXICO	$3,287	100.0%	$1,010	30.8%	$478	14.5%	$280	7.9%	$99	3.0%	$1,448	44.0%
NEW YORK	$5,585	100.0%	$1,370	24.5%	$809	14.5%	$565	10.1%	$115	2.1%	$2,726	48.8%
NORTH CAROLINA	$3,630	100.0%	$1,220	33.6%	$510	14.1%	$317	8.7%	$111	3.1%	$1,472	40.5%
NORTH DAKOTA	$4,193	100.0%	$1,448	34.5%	$1,013	24.2%	$292	7.0%	$131	3.1%	$1,311	31.3%
OHIO	$4,474	100.0%	$1,382	30.9%	$973	21.8%	$367	8.2%	$121	2.7%	$1,801	33.8%
OKLAHOMA	$3,786	100.0%	$1,347	35.8%	$522	13.8%	$288	7.5%	$120	3.2%	$1,512	39.9%
OREGON	$3,900	100.0%	$1,194	30.6%	$648	16.6%	$330	8.5%	$123	3.1%	$1,605	41.2%
PENNSYLVANIA	$4,300	100.0%	$1,421	33.0%	$892	20.7%	$381	8.1%	$140	3.2%	$1,457	33.9%
RHODE ISLAND	$4,814	100.0%	$1,468	30.3%	$875	17.6%	$405	8.2%	$131	2.7%	$2,014	41.0%
SOUTH CAROLINA	$3,414	100.0%	$1,031	29.9%	$490	14.4%	$272	8.0%	$106	3.1%	$1,525	44.7%
SOUTH DAKOTA	$3,863	100.0%	$1,448	37.5%	$912	23.6%	$255	6.6%	$136	3.5%	$1,109	28.7%
TENNESSEE	$3,487	100.0%	$1,436	41.2%	$812	17.8%	$322	9.2%	$116	3.3%	$1,001	28.7%
TEXAS	$4,095	100.0%	$1,526	37.3%	$580	14.2%	$319	7.7%	$93	2.3%	$1,581	38.8%
UTAH	$3,662	100.0%	$1,136	30.9%	$669	18.2%	$298	8.1%	$93	2.5%	$1,485	40.3%
VERMONT	$3,648	100.0%	$1,186	33.0%	$694	18.0%	$318	9.7%	$107	2.9%	$1,367	37.4%
VIRGINIA	$4,358	100.0%	$1,345	30.8%	$571	13.1%	$325	7.5%	$97	2.2%	$2,020	46.4%
WASHINGTON	$3,710	100.0%	$1,071	28.9%	$587	15.8%	$309	8.3%	$100	2.7%	$1,842	44.3%
WEST VIRGINIA	$3,443	100.0%	$1,313	38.1%	$542	15.7%	$242	7.0%	$138	4.0%	$1,207	35.1%
WISCONSIN	$4,245	100.0%	$1,338	31.5%	$958	22.6%	$383	9.3%	$123	2.9%	$1,431	33.7%
WYOMING	$3,474	100.0%	$970	27.8%	$548	15.6%	$305	8.8%	$98	2.8%	$1,552	44.7%

* Families are groups of one or more persons related by birth, marriage, or adoption and who are residing together. Parents and adult children residing with other family members were counted as separate units.

** Health care payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures: the administrative costs of public programs; and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

***General taxes include federal contributions to Medicare, the federal and state components of Medicaid, federal and state government contributions to employer-sponsored insurance, and funding for other federal and state public programs. Other public programs include public and general and general assistance, Maternal and Child Health, Vocational Rehabilitation, and other public activities.

TABLE 4C

HOW FAMILIES WILL PAY* FOR HEALTH CARE** 2000

State	TOTAL FAMILY		OUT-OF-POCKET		INSURANCE		MEDICARE PAYROLL TAX		MEDICARE PREMIUMS		GENERAL TAXES***	
	Per Family	%	Per Family	%	Per Family	%	Per Family	%	Per Family	%	Per Family	%
TOTAL	$8,397	100.0%	$2,562	27.3%	$1,810	17.1%	$805	8.6%	$219	2.3%	$4,400	46.8%
ALABAMA	$6,893	100.0%	$2,818	31.7%	$1,369	15.4%	$455	5.1%	$236	2.7%	$4,015	45.1%
ALASKA	$7,260	100.0%	$2,543	35.0%	$1,564	21.5%	$374	5.2%	$82	1.1%	$2,697	37.1%
ARIZONA	$7,222	100.0%	$2,074	28.7%	$1,267	17.5%	$663	9.4%	$228	3.2%	$3,191	44.2%
ARKANSAS	$7,578	100.0%	$2,412	31.8%	$1,056	13.9%	$518	6.8%	$260	3.4%	$3,332	44.0%
CALIFORNIA	$8,785	100.0%	$2,667	27.3%	$1,661	17.0%	$800	8.1%	$178	1.8%	$4,859	47.7%
COLORADO	$6,568	100.0%	$2,293	29.7%	$1,496	17.4%	$517	8.0%	$168	2.0%	$4,113	47.9%
CONNECTICUT	$12,100	100.0%	$2,798	23.1%	$2,234	18.5%	$948	7.8%	$236	2.0%	$5,880	48.8%
DELAWARE	$9,055	100.0%	$2,498	27.8%	$1,292	14.3%	$825	9.1%	$209	2.3%	$4,230	46.7%
DISTRICT OF COLUMBIA	$8,445	100.0%	$1,743	18.4%	$800	8.8%	$1,221	12.9%	$183	1.7%	$5,508	58.2%
FLORIDA	$8,235	100.0%	$2,662	32.8%	$1,226	14.8%	$426	5.2%	$292	3.5%	$3,607	43.8%
GEORGIA	$8,864	100.0%	$2,500	28.1%	$1,221	13.7%	$566	6.4%	$182	2.0%	$4,414	49.7%
HAWAII	$8,968	100.0%	$2,564	25.6%	$1,707	17.1%	$478	4.8%	$222	2.2%	$4,987	50.0%
IDAHO	$8,728	100.0%	$1,781	20.8%	$1,138	18.0%	$487	8.0%	$220	3.3%	$3,110	46.2%
ILLINOIS	$10,423	100.0%	$2,824	27.1%	$2,173	20.8%	$708	6.8%	$215	2.1%	$4,505	43.2%
INDIANA	$8,770	100.0%	$2,361	26.8%	$1,832	20.8%	$540	6.2%	$222	2.5%	$3,815	43.5%
IOWA	$9,021	100.0%	$2,499	27.7%	$2,017	22.4%	$531	5.9%	$267	3.0%	$3,707	41.1%
KANSAS	$9,637	100.0%	$2,824	28.7%	$2,236	22.7%	$568	5.8%	$244	2.5%	$3,965	40.3%
KENTUCKY	$7,177	100.0%	$2,060	28.7%	$969	13.8%	$397	5.5%	$229	3.2%	$3,503	48.8%
LOUISIANA	$8,311	100.0%	$2,491	29.3%	$1,183	13.8%	$480	5.8%	$212	2.5%	$4,145	48.7%
MAINE	$8,840	100.0%	$2,292	26.5%	$1,765	20.7%	$449	5.2%	$242	2.8%	$3,672	44.8%
MARYLAND	$9,878	100.0%	$2,508	25.4%	$1,298	13.1%	$622	6.3%	$177	1.8%	$5,273	53.4%
MASSACHUSETTS	$11,834	100.0%	$2,873	24.1%	$2,118	17.7%	$753	6.3%	$220	1.8%	$5,966	50.0%
MICHIGAN	$10,054	100.0%	$2,871	28.8%	$2,195	21.8%	$770	7.7%	$222	2.2%	$4,197	41.7%
MINNESOTA	$8,864	100.0%	$2,667	27.0%	$2,111	21.4%	$587	8.0%	$317	3.2%	$4,262	43.4%
MISSISSIPPI	$8,598	100.0%	$2,082	31.8%	$818	13.8%	$348	5.2%	$223	3.4%	$3,018	45.8%
MISSOURI	$9,426	100.0%	$2,766	29.8%	$2,136	22.7%	$610	6.5%	$243	2.8%	$3,649	38.7%
MONTANA	$7,150	100.0%	$1,837	25.7%	$1,103	15.4%	$415	5.8%	$228	3.2%	$3,567	49.9%
NEBRASKA	$8,348	100.0%	$2,742	29.3%	$2,133	22.8%	$566	6.3%	$248	2.8%	$3,638	38.9%
NEVADA	$8,364	100.0%	$2,462	29.3%	$1,552	18.5%	$424	5.0%	$173	2.1%	$3,783	45.1%
NEW HAMPSHIRE	$8,050	100.0%	$2,418	30.1%	$1,568	18.5%	$610	7.8%	$192	2.4%	$3,263	40.5%
NEW JERSEY	$10,752	100.0%	$2,373	22.1%	$1,718	18.0%	$844	7.8%	$235	2.2%	$5,582	51.9%
NEW MEXICO	$7,109	100.0%	$1,910	26.8%	$1,065	15.3%	$437	6.2%	$193	2.7%	$3,484	49.0%
NEW YORK	$12,990	100.0%	$2,580	20.2%	$1,753	14.1%	$944	7.4%	$224	1.8%	$7,148	56.3%
NORTH CAROLINA	$7,794	100.0%	$2,278	29.2%	$1,125	14.4%	$521	6.7%	$227	2.9%	$3,641	46.7%
NORTH DAKOTA	$8,229	100.0%	$2,723	29.3%	$2,187	25.7%	$488	5.2%	$256	2.8%	$3,575	38.7%
OHIO	$9,899	100.0%	$2,580	26.2%	$2,096	21.2%	$656	6.6%	$238	2.4%	$4,314	43.6%
OKLAHOMA	$8,364	100.0%	$2,534	30.2%	$1,155	13.8%	$477	5.7%	$234	2.8%	$3,966	47.4%
OREGON	$8,772	100.0%	$2,258	25.7%	$1,466	16.7%	$559	6.4%	$227	2.6%	$4,262	48.6%
PENNSYLVANIA	$9,571	100.0%	$2,662	27.8%	$1,950	20.4%	$650	6.8%	$271	2.8%	$4,038	42.2%
RHODE ISLAND	$10,862	100.0%	$2,812	25.9%	$1,944	17.9%	$666	6.2%	$243	2.2%	$5,178	47.7%
SOUTH CAROLINA	$7,474	100.0%	$1,908	25.5%	$1,082	14.5%	$449	6.0%	$216	2.9%	$3,818	51.1%
SOUTH DAKOTA	$8,368	100.0%	$2,735	32.7%	$1,880	23.8%	$428	5.1%	$264	3.2%	$2,947	35.2%
TENNESSEE	$7,401	100.0%	$2,666	36.3%	$1,334	18.0%	$532	7.2%	$234	3.2%	$2,816	35.2%
TEXAS	$8,789	100.0%	$2,863	32.8%	$1,278	14.5%	$527	6.0%	$187	2.1%	$3,913	44.5%
UTAH	$8,184	100.0%	$2,169	26.5%	$1,532	18.7%	$506	6.2%	$184	2.3%	$3,793	46.3%
VERMONT	$7,974	100.0%	$2,200	27.8%	$1,529	18.2%	$531	6.7%	$202	2.5%	$3,512	44.0%
VIRGINIA	$8,631	100.0%	$2,530	29.3%	$1,258	13.1%	$542	5.6%	$193	2.0%	$5,108	53.0%
WASHINGTON	$8,361	100.0%	$2,023	24.2%	$1,530	15.9%	$519	6.2%	$193	2.3%	$4,096	51.4%
WEST VIRGINIA	$7,706	100.0%	$2,480	31.9%	$1,186	15.4%	$462	5.2%	$272	3.5%	$3,363	43.9%
WISCONSIN	$8,337	100.0%	$2,517	27.0%	$2,078	22.2%	$656	7.0%	$240	2.8%	$3,848	41.2%
WYOMING	$7,845	100.0%	$1,838	23.1%	$1,242	15.8%	$515	6.5%	$188	2.4%	$4,163	52.4%

* Families are groups of one or more persons related by birth, marriage, or adoption and who are residing together. Parents and adult children residing with other family members were counted as separate units.

** Health care payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

***General taxes include federal contributions to Medicare, the federal and state components of Medicaid, federal and state government contributions to employer-sponsored insurance, and funding for other federal and state public programs. Other public programs include public and general and general assistance, Maternal and Child Health, Vocational Rehabilitation, and other public activities.

TABLE 5A

HOW BUSINESS PAID FOR HEALTH CARE* 1990
(amounts in millions of dollars)

STATE	TOTAL BUSINESS		INSURANCE		MEDICARE PAYROLL TAX		GENERAL TAXES**		OTHER***	
		%		%		%		%		%
TOTAL	74,083	100.0%	43,268	58.4%	11,745	15.9%	13,070	17.6%	6,000	8.1%
ALABAMA	826	100.0%	438	53.0%	152	18.3%	178	21.3%	61	7.4%
ALASKA	185	100.0%	66	36.0%	8	4.7%	77	41.7%	33	17.7%
ARIZONA	800	100.0%	455	56.9%	120	15.0%	160	20.0%	65	8.2%
ARKANSAS	440	100.0%	217	49.5%	85	19.3%	92	21.0%	45	10.3%
CALIFORNIA	8,971	100.0%	4,867	54.5%	1,256	14.0%	1,940	21.6%	865	9.0%
COLORADO	968	100.0%	810	82.9%	146	15.1%	151	15.6%	62	6.4%
CONNECTICUT	1,519	100.0%	868	57.0%	196	13.0%	383	25.2%	72	4.7%
DELAWARE	184	100.0%	68	53.4%	41	24.7%	25	14.0%	11	6.0%
DISTRICT OF COLUMBIA	180	100.0%	20	11.2%	64	35.6%	58	32.2%	38	20.6%
FLORIDA	2,227	100.0%	1,108	48.7%	402	18.0%	520	23.4%	197	8.8%
GEORGIA	1,245	100.0%	669	53.6%	232	18.6%	243	18.5%	101	8.1%
HAWAII	305	100.0%	181	59.2%	45	14.7%	47	15.4%	33	10.7%
IDAHO	220	100.0%	117	53.2%	43	19.6%	39	17.6%	21	9.4%
ILLINOIS	4,583	100.0%	2,811	63.6%	687	15.1%	803	13.2%	382	7.9%
INDIANA	1,787	100.0%	1,233	69.0%	268	18.1%	208	11.5%	80	3.3%
IOWA	978	100.0%	857	87.3%	142	14.5%	124	12.7%	54	5.5%
KANSAS	830	100.0%	532	64.1%	115	13.8%	137	16.5%	48	6.5%
KENTUCKY	827	100.0%	467	56.5%	132	15.9%	140	16.9%	88	10.6%
LOUISIANA	1,310	100.0%	538	41.2%	185	14.1%	422	32.2%	164	12.5%
MAINE	310	100.0%	185	59.7%	41	13.1%	40	13.0%	44	14.2%
MARYLAND	1,180	100.0%	704	59.7%	205	17.3%	170	14.4%	102	8.6%
MASSACHUSETTS	2,328	100.0%	1,537	66.0%	305	13.1%	325	14.0%	161	6.9%
MICHIGAN	3,832	100.0%	2,353	61.4%	579	15.1%	560	14.6%	340	8.9%
MINNESOTA	1,840	100.0%	1,035	63.1%	257	15.7%	208	12.7%	140	8.5%
MISSISSIPPI	455	100.0%	234	51.4%	78	18.7%	112	24.7%	33	7.2%
MISSOURI	1,801	100.0%	1,115	68.8%	254	15.9%	185	10.3%	87	4.2%
MONTANA	211	100.0%	111	52.7%	33	15.6%	45	21.2%	22	10.6%
NEBRASKA	525	100.0%	358	68.3%	78	14.9%	66	12.5%	23	4.3%
NEVADA	308	100.0%	177	57.9%	38	12.4%	54	17.6%	38	12.3%
NEW HAMPSHIRE	319	100.0%	172	54.0%	43	13.5%	78	24.3%	26	8.2%
NEW JERSEY	2,823	100.0%	1,804	61.1%	417	15.0%	430	18.4%	172	8.6%
NEW MEXICO	329	100.0%	132	40.0%	51	15.4%	117	35.6%	28	8.9%
NEW YORK	8,717	100.0%	4,084	60.8%	1,207	18.0%	1,080	18.1%	346	6.2%
NORTH CAROLINA	1,237	100.0%	680	55.0%	258	20.9%	227	18.4%	71	5.6%
NORTH DAKOTA	230	100.0%	148	65.0%	26	12.3%	43	18.6%	9	4.0%
OHIO	4,315	100.0%	2,747	63.7%	610	14.1%	536	12.4%	422	9.8%
OKLAHOMA	700	100.0%	341	48.7%	144	20.5%	143	20.4%	73	10.4%
OREGON	860	100.0%	451	52.5%	134	15.6%	125	14.6%	148	17.4%
PENNSYLVANIA	4,291	100.0%	2,715	63.3%	641	14.9%	624	14.5%	311	7.2%
RHODE ISLAND	365	100.0%	254	65.9%	48	12.6%	53	13.7%	30	7.8%
SOUTH CAROLINA	550	100.0%	238	43.3%	123	22.4%	148	26.8%	43	7.8%
SOUTH DAKOTA	193	100.0%	131	67.8%	26	14.3%	26	14.3%	7	3.7%
TENNESSEE	1,472	100.0%	626	42.5%	218	14.7%	558	38.0%	70	4.6%
TEXAS	3,810	100.0%	1,930	50.6%	735	19.3%	764	20.1%	381	10.0%
UTAH	324	100.0%	204	63.1%	50	15.3%	49	15.0%	21	6.5%
VERMONT	136	100.0%	89	65.7%	21	15.3%	17	12.6%	8	6.0%
VIRGINIA	1,178	100.0%	641	54.5%	221	18.6%	218	18.7%	94	8.0%
WASHINGTON	1,348	100.0%	682	50.7%	202	15.0%	286	21.2%	178	13.1%
WEST VIRGINIA	456	100.0%	239	52.2%	75	16.3%	48	10.6%	96	20.9%
WISCONSIN	1,784	100.0%	1,222	69.3%	265	15.0%	183	10.4%	94	6.3%
WYOMING	119	100.0%	64	54.0%	20	16.6%	27	22.6%	8	6.4%

* Health care payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

** General taxes include federal contributions to Medicare, the federal and state components of Medicaid, federal and state government contributions to employer sponsored insurance, and funding for other federal and state public programs. Other public programs include public and general assistance, Maternal and Child Health, Vocational Rehabilitation, and other public health activities.

*** Other

TABLE 58

HOW BUSINESS PAYS FOR HEALTH CARE* 1991
(amounts in millions of dollars)

STATE	TOTAL BUSINESS		INSURANCE		MEDICARE PAYROLL TAX		GENERAL TAXES**		OTHER***	
		%		%		%		%		%
TOTAL	237,841	100.0%	131,360	55.3%	39,204	16.5%	47,965	20.2%	19,112	8.0%
ALABAMA	2,580	100.0%	1,332	51.6%	459	17.8%	577	22.4%	212	8.2%
ALASKA	854	100.0%	283	33.1%	119	14.0%	345	40.4%	108	12.6%
ARIZONA	3,002	100.0%	1,830	61.0%	447	14.9%	552	18.4%	172	5.7%
ARKANSAS	1,313	100.0%	580	44.2%	313	23.8%	296	22.6%	124	9.4%
CALIFORNIA	35,109	100.0%	20,382	58.1%	4,621	13.2%	6,817	19.4%	3,290	9.4%
COLORADO	3,264	100.0%	1,966	60.5%	478	14.6%	506	15.5%	311	9.5%
CONNECTICUT	5,327	100.0%	2,699	50.7%	777	14.6%	1,515	28.4%	336	6.3%
DELAWARE	667	100.0%	264	39.7%	216	32.4%	148	21.6%	39	5.9%
DISTRICT OF COLUMBIA	541	100.0%	49	9.1%	278	51.4%	148	27.1%	67	12.4%
FLORIDA	9,506	100.0%	4,630	48.7%	1,522	16.0%	2,442	25.7%	912	9.6%
GEORGIA	4,361	100.0%	2,018	46.2%	907	20.8%	1,043	23.8%	395	9.1%
HAWAII	1,173	100.0%	744	63.4%	154	13.1%	169	14.4%	106	9.0%
IDAHO	664	100.0%	383	54.6%	115	17.4%	132	19.6%	54	8.2%
ILLINOIS	13,248	100.0%	8,221	62.1%	2,066	15.6%	2,134	16.1%	827	6.2%
INDIANA	4,705	100.0%	3,058	65.0%	782	16.6%	709	15.1%	156	3.3%
IOWA	2,613	100.0%	1,663	64.4%	394	15.1%	427	16.3%	109	4.2%
KANSAS	2,819	100.0%	1,706	65.1%	359	13.7%	419	16.0%	135	5.2%
KENTUCKY	2,106	100.0%	940	44.6%	360	16.0%	574	27.3%	212	10.1%
LOUISIANA	3,208	100.0%	1,200	37.4%	497	15.5%	1,088	33.9%	421	13.1%
MAINE	1,178	100.0%	655	55.7%	136	11.5%	171	14.5%	214	18.2%
MARYLAND	3,607	100.0%	1,720	47.7%	793	22.0%	804	22.3%	289	8.0%
MASSACHUSETTS	8,238	100.0%	5,038	61.2%	1,189	14.2%	1,480	17.7%	568	6.9%
MICHIGAN	10,809	100.0%	6,203	56.5%	1,766	16.7%	1,954	18.4%	885	8.5%
MINNESOTA	5,144	100.0%	3,205	62.3%	818	15.9%	742	14.4%	379	7.4%
MISSISSIPPI	1,228	100.0%	491	40.0%	222	18.1%	409	33.3%	106	8.6%
MISSOURI	5,172	100.0%	3,435	66.4%	802	15.5%	888	13.3%	246	4.8%
MONTANA	817	100.0%	294	47.7%	87	14.1%	128	20.8%	107	17.3%
NEBRASKA	1,589	100.0%	1,045	65.8%	245	15.4%	231	14.5%	68	4.3%
NEVADA	1,327	100.0%	843	63.5%	140	10.5%	205	15.4%	139	10.5%
NEW HAMPSHIRE	1,285	100.0%	632	49.2%	172	13.4%	382	29.7%	99	7.7%
NEW JERSEY	6,777	100.0%	4,856	53.0%	1,627	16.5%	2,009	22.6%	485	6.6%
NEW MEXICO	849	100.0%	445	48.0%	163	17.1%	226	24.1%	113	11.0%
NEW YORK	20,117	100.0%	10,918	54.3%	4,329	21.5%	3,935	19.6%	934	4.6%
NORTH CAROLINA	4,104	100.0%	1,976	48.2%	884	21.6%	1,033	25.2%	211	5.1%
NORTH DAKOTA	640	100.0%	391	61.2%	80	12.5%	134	21.0%	34	5.3%
OHIO	11,412	100.0%	6,782	59.3%	1,789	15.7%	1,852	14.5%	1,209	10.6%
OKLAHOMA	1,875	100.0%	861	45.9%	384	20.5%	406	21.7%	224	11.9%
OREGON	2,664	100.0%	1,487	55.8%	410	15.4%	372	14.0%	395	14.8%
PENNSYLVANIA	12,700	100.0%	7,527	59.3%	1,997	15.8%	2,222	17.5%	954	7.5%
RHODE ISLAND	1,157	100.0%	691	59.8%	171	14.8%	183	15.8%	111	9.6%
SOUTH CAROLINA	1,844	100.0%	853	46.3%	383	20.8%	454	24.6%	144	7.8%
SOUTH DAKOTA	598	100.0%	392	65.6%	74	12.4%	102	17.1%	28	4.7%
TENNESSEE	4,402	100.0%	1,586	36.3%	658	15.0%	1,923	43.7%	224	5.1%
TEXAS	12,819	100.0%	5,994	47.5%	2,215	17.6%	2,806	22.2%	1,605	12.7%
UTAH	1,234	100.0%	735	59.6%	163	14.8%	219	17.7%	96	7.8%
VERMONT	463	100.0%	293	80.7%	78	16.2%	80	16.5%	32	6.6%
VIRGINIA	3,999	100.0%	1,857	46.8%	841	21.0%	926	23.2%	274	6.9%
WASHINGTON	4,819	100.0%	2,483	53.8%	674	14.6%	937	20.3%	525	11.4%
WEST VIRGINIA	1,236	100.0%	453	36.6%	181	14.6%	328	26.5%	275	22.2%
WISCONSIN	5,002	100.0%	3,180	63.6%	817	16.3%	720	14.4%	286	5.7%
WYOMING	344	100.0%	171	49.6%	56	16.6%	80	23.4%	35	10.1%

* Health care payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

** General taxes include federal contributions to Medicare, the federal and state components of Medicaid, federal and state government contributions to employer sponsored insurance and funding for other federal and state public programs. Other public programs include public and general assistance, Maternal and Child Health, Vocational Rehabilitation and other public health activities.

TABLE 8C

HOW BUSINESS WILL PAY FOR HEALTH CARE* 2000
(amounts in millions of dollars)

STATE	TOTAL BUSINESS		INSURANCE		MEDICARE PAYROLL TAX		GENERAL TAXES**		OTHER***	
		%		%		%		%		%
TOTAL	511,439	100.0%	271,613	53.1%	68,566	13.4%	125,081	24.5%	46,200	9.0%
ALABAMA	5,587	100.0%	2,737	49.0%	807	14.4%	1,538	27.5%	504	9.0%
ALASKA	2,183	100.0%	698	32.3%	104	4.8%	1,054	48.7%	308	14.2%
ARIZONA	7,862	100.0%	4,809	60.2%	980	12.5%	1,593	20.6%	499	6.5%
ARKANSAS	2,770	100.0%	1,178	42.6%	542	19.6%	759	27.4%	291	10.5%
CALIFORNIA	61,334	100.0%	46,634	56.1%	6,614	10.8%	18,392	22.6%	8,494	10.4%
COLORADO	7,414	100.0%	4,360	58.8%	696	12.1%	1,371	18.5%	788	10.6%
CONNECTICUT	11,604	100.0%	5,564	48.0%	1,363	11.7%	3,870	33.4%	796	6.9%
DELAWARE	1,325	100.0%	562	42.4%	276	20.8%	390	29.5%	97	7.3%
DISTRICT OF COLUMBIA	1,007	100.0%	99	9.8%	378	37.7%	375	37.2%	154	15.3%
FLORIDA	23,780	100.0%	11,090	46.7%	3,107	13.1%	7,043	29.6%	2,520	10.6%
GEORGIA	10,753	100.0%	4,845	45.1%	1,863	17.3%	2,946	27.4%	1,097	10.2%
HAWAII	2,718	100.0%	1,720	63.3%	262	9.6%	451	16.6%	283	10.4%
IDAHO	1,378	100.0%	722	52.5%	196	14.2%	334	24.3%	124	9.0%
ILLINOIS	26,062	100.0%	15,732	60.3%	3,366	12.9%	5,161	19.8%	1,823	7.0%
INDIANA	9,218	100.0%	5,820	63.1%	1,286	13.7%	1,790	19.4%	343	3.7%
IOWA	4,718	100.0%	2,910	61.7%	560	12.3%	1,010	21.4%	217	4.6%
KANSAS	5,250	100.0%	3,323	63.2%	596	11.3%	1,037	19.7%	304	5.8%
KENTUCKY	4,348	100.0%	1,802	41.5%	622	14.3%	1,452	33.4%	470	10.8%
LOUISIANA	6,907	100.0%	2,333	33.8%	824	11.9%	2,806	40.6%	945	13.7%
MAINE	2,518	100.0%	1,339	53.2%	236	9.4%	435	17.3%	508	20.1%
MARYLAND	8,090	100.0%	3,746	46.3%	1,482	18.3%	2,127	26.3%	733	9.1%
MASSACHUSETTS	17,070	100.0%	10,107	59.2%	1,997	11.7%	3,654	21.4%	1,313	7.7%
MICHIGAN	21,218	100.0%	11,980	56.4%	2,901	13.7%	4,837	22.8%	1,522	7.2%
MINNESOTA	10,308	100.0%	6,425	62.3%	1,146	11.1%	1,861	18.1%	876	8.5%
MISSISSIPPI	2,774	100.0%	1,030	37.1%	398	14.4%	1,089	39.3%	257	9.3%
MISSOURI	10,862	100.0%	5,942	55.0%	1,381	12.9%	1,782	16.7%	577	5.4%
MONTANA	1,257	100.0%	559	44.4%	141	11.2%	323	25.7%	234	18.6%
NEBRASKA	3,047	100.0%	1,948	63.9%	389	12.8%	566	18.6%	148	4.8%
NEVADA	3,235	100.0%	1,999	61.8%	282	8.7%	574	17.7%	381	11.8%
NEW HAMPSHIRE	3,183	100.0%	1,506	47.2%	350	10.9%	1,064	33.3%	272	8.5%
NEW JERSEY	19,275	100.0%	9,940	51.6%	2,958	15.3%	5,182	26.9%	1,195	6.2%
NEW MEXICO	2,445	100.0%	1,106	45.3%	348	14.2%	666	27.2%	326	13.3%
NEW YORK	40,008	100.0%	21,076	52.7%	7,115	17.8%	9,736	24.3%	2,078	5.2%
NORTH CAROLINA	9,348	100.0%	4,362	46.7%	1,664	17.8%	2,785	29.8%	536	5.7%
NORTH DAKOTA	1,225	100.0%	706	57.6%	123	10.1%	322	26.3%	71	5.8%
OHIO	22,292	100.0%	12,743	57.2%	2,870	12.9%	4,053	18.2%	2,626	11.8%
OKLAHOMA	3,942	100.0%	1,718	43.6%	656	16.7%	1,050	26.6%	517	13.1%
OREGON	5,671	100.0%	2,996	53.6%	704	12.6%	951	17.1%	916	16.5%
PENNSYLVANIA	24,576	100.0%	13,876	56.9%	3,112	12.7%	5,370	21.9%	2,106	8.6%
RHODE ISLAND	2,452	100.0%	1,422	58.0%	300	12.3%	466	19.0%	263	10.7%
SOUTH CAROLINA	4,130	100.0%	1,854	44.9%	703	17.0%	1,218	29.4%	357	8.7%
SOUTH DAKOTA	1,165	100.0%	757	63.9%	121	10.2%	243	20.7%	62	5.2%
TENNESSEE	10,065	100.0%	3,268	32.8%	1,158	11.5%	5,108	50.8%	532	5.3%
TEXAS	29,836	100.0%	13,598	45.8%	4,266	14.4%	7,748	26.0%	4,205	14.1%
UTAH	2,802	100.0%	1,613	57.6%	343	12.2%	599	21.4%	248	8.8%
VERMONT	1,012	100.0%	601	59.3%	137	13.5%	200	19.7%	75	7.4%
VIRGINIA	8,989	100.0%	4,257	47.4%	1,570	17.5%	2,469	27.5%	693	7.7%
WASHINGTON	9,994	100.0%	5,122	51.2%	1,186	11.9%	2,437	24.4%	1,248	12.5%
WEST VIRGINIA	2,432	100.0%	802	33.0%	273	11.2%	795	32.7%	562	23.1%
WISCONSIN	9,741	100.0%	6,039	62.0%	1,321	13.6%	1,756	18.0%	625	6.4%
WYOMING	706	100.0%	331	46.8%	96	13.6%	203	28.7%	76	11.0%

* Health care payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

** General taxes include federal contributions to Medicare, the federal and state components of Medicaid, federal and state government contributions to employer-sponsored insurance, and funding for other federal and state public programs. Other public programs include public and general assistance, Maternal and Child Health, Vocational Rehabilitation, and other public health activities.

*** The Other business component of health care spending covers worker's compensation and temporary disability and industrial in-plan health benefits.

TABLE 6

TOTAL HEALTH SPENDING* PER FAMILY** (PAID BY FAMILIES AND BUSINESSES)

State	1990	1991	2000
TOTAL	$2,572	$6,835	$13,911
ALABAMA	2,287	5,604	$12,041
ALASKA	2,706	$7,756	$15,081
ARIZONA	1,995	$5,321	$10,919
ARKANSAS	1,951	$4,781	$10,213
CALIFORNIA	2,553	$7,141	$15,300
COLORADO	2,463	$6,073	$12,666
CONNECTICUT	3,252	$9,312	$20,174
DELAWARE	2,642	$6,573	$13,021
DISTRICT OF COLUMBIA	2,247	$6,054	$12,665
FLORIDA	1,973	$5,556	$11,512
GEORGIA	2,263	$5,762	$12,164
HAWAII	2,701	$7,190	$14,661
IDAHO	1,805	$4,599	$10,011
ILLINOIS	3,069	$7,370	$15,667
INDIANA	2,457	$5,930	$12,569
IOWA	2,708	$6,146	$13,344
KANSAS	2,666	$6,658	$14,554
KENTUCKY	2,146	$4,535	$9,952
LOUISIANA	2,483	$5,677	$12,531
MAINE	2,213	$6,266	$13,422
MARYLAND	2,812	$6,161	$13,274
MASSACHUSETTS	3,089	$8,484	$18,365
MICHIGAN	2,857	$7,337	$15,564
MINNESOTA	2,938	$7,252	$15,144
MISSISSIPPI	1,806	$4,156	$9,011
MISSOURI	2,586	$6,715	$14,144
MONTANA	2,006	$4,810	$10,841
NEBRASKA	2,656	$6,554	$13,953
NEVADA	2,338	$6,290	$13,264
NEW HAMPSHIRE	2,244	$6,581	$13,923
NEW JERSEY	2,928	$7,586	$16,249
NEW MEXICO	1,878	$4,615	$10,189
NEW YORK	3,135	$8,210	$17,999
NORTH CAROLINA	2,085	$5,101	$10,722
NORTH DAKOTA	2,713	$6,528	$14,077
OHIO	2,963	$7,005	$15,009
OKLAHOMA	2,194	$5,178	$11,227
OREGON	2,178	$6,045	$13,199
PENNSYLVANIA	2,875	$6,825	$14,700
RHODE ISLAND	2,946	$7,647	$16,459
SOUTH CAROLINA	1,947	$4,722	$10,112
SOUTH DAKOTA	2,367	$5,919	$12,547
TENNESSEE	2,313	$5,539	$12,031
TEXAS	2,483	$6,091	$12,458
UTAH	2,082	$5,899	$12,326
VERMONT	1,969	$5,506	$11,909
VIRGINIA	2,218	$6,906	$12,738
WASHINGTON	2,244	$5,628	$12,739
WEST VIRGINIA	2,217	$5,095	$11,292
WISCONSIN	2,751	$6,651	$14,175
WYOMING	2,002	$5,264	$11,744

* Health payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenue, research and construction.

** Families are groups of one or more persons related by birth, marriage, or adoption and who are residing together. Parents and adult children residing with other family members were counted as separate units.

TABLE 7

FINANCING OUR HEALTH SYSTEM*
(amounts in millions of dollars)

STATE	1990				1991				2000			
	FAMILIES**		BUSINESSES		FAMILIES		BUSINESSES		FAMILIES		BUSINESSES	
		%		%		%		%		%		%
TOTAL	185 317	67.7%	74 063	32.3%	458 058	65.7%	237 641	34.3%	1 064 891	67.6%	311 436	32.4%
ALABAMA	3 431	74.6%	826	26.4%	8 805	72.5%	3 586	37.5%	18 781	73.9%	6 567	26.1%
ALASKA	643	56.9%	183	43.3%	640	49.6%	654	50.4%	2 008	48.1%	2 183	51.9%
ARIZONA	1 924	65.6%	900	34.4%	5 484	64.8%	3 002	35.4%	14 870	66.1%	7 887	33.9%
ARKANSAS	1 252	74.0%	440	26.0%	2 814	72.5%	1 313	27.2%	7 488	74.2%	2 770	25.8%
CALIFORNIA	18 845	65.2%	9 871	34.8%	87 474	62.1%	35,106	37.9%	143 486	63.6%	81 334	36.2%
COLORADO	1 949	66.5%	966	33.2%	6 032	64.6%	3 294	35.2%	14 849	66.6%	7 414	33.2%
CONNECTICUT	2 474	62.0%	1,518	38.0%	7,423	58.2%	5,327	41.8%	17 366	60.0%	11 604	40.0%
DELAWARE	432	72.4%	164	27.6%	1,843	66.6%	867	33.2%	3 026	66.6%	1 328	30.5%
DISTRICT OF COLUMBIA	529	74.8%	180	26.4%	1,327	71.0%	841	26.0%	2 837	74.6%	1,067	28.6%
FLORIDA	8 377	74.1%	3,227	29.8%	23 028	70.6%	8,808	29.2%	84 790	71.8%	33 780	28.6%
GEORGIA	3,361	73.0%	1,246	27.0%	11,110	71.6%	4,361	28.7%	29 129	73.0%	10,783	27.0%
HAWAII	641	67.7%	305	32.3%	2 076	63.8%	1,173	36.1%	6 869	66.8%	6 718	33.2%
IDAHO	436	66.6%	220	33.4%	1,262	66.3%	664	34.7%	2 818	67.2%	1,378	32.8%
ILLINOIS	6 554	65.2%	4,583	34.8%	22,610	63.4%	12,248	36.6%	48 882	63.6%	29 082	34.4%
INDIANA	3,807	66.8%	1,787	33.1%	8,648	67.0%	4,709	33.0%	20 373	66.1%	8,216	30.9%
IOWA	2,018	67.4%	878	32.6%	4 958	65.5%	2,813	34.6%	8,844	67.6%	4,710	33.4%
KANSAS	1 870	64.6%	830	33.2%	4,734	64.4%	2,618	35.6%	10 512	66.2%	5 256	33.8%
KENTUCKY	2,029	71.0%	827	29.0%	8,081	70.7%	3,106	29.3%	11,236	72.1%	4,348	27.9%
LOUISIANA	2,863	67.0%	1,310	33.0%	8,838	67.1%	3,206	33.8%	14 874	67.9%	6 907	32.1%
MAINE	934	67.2%	316	32.8%	1,866	63.0%	1,176	37.0%	4,846	64.4%	2 613	36.6%
MARYLAND	3 173	72.8%	1,180	27.1%	9 027	72.6%	3,407	27.5%	23 830	74.4%	8 099	26.8%
MASSACHUSETTS	4 878	66.6%	2,326	33.2%	13 602	62.7%	8,256	37.3%	31 500	64.8%	17,070	35.1%
MICHIGAN	6 863	63.8%	3,932	36.4%	17,516	63.3%	10,908	37.7%	37,986	64.1%	21,319	35.9%
MINNESOTA	3,102	65.4%	1,640	34.8%	8,753	63.0%	5,144	37.0%	19,296	65.1%	10,308	34.8%
MISSISSIPPI	1 173	72.1%	455	27.9%	3 318	72.4%	1,276	27.8%	7,843	73.1%	2,774	25.8%
MISSOURI	3,432	66.2%	1,901	31.8%	8,567	65.0%	5,173	39.0%	21,366	66.7%	10,663	33.3%
MONTANA	428	67.0%	211	33.0%	1,108	64.3%	617	35.8%	2 638	66.0%	1,357	34.0%
NEBRASKA	1,110	67.9%	526	32.1%	2 666	65.1%	1,586	34.8%	9,186	67.0%	3 047	37.0%
NEVADA	838	64.8%	308	35.4%	2,161	62.0%	1,327	36.0%	8 666	63.3%	3,939	36.7%
NEW HAMPSHIRE	814	61.6%	313	38.1%	1,836	58.6%	1,266	41.2%	4 818	66.1%	3,183	40.9%
NEW JERSEY	3,166	66.2%	2,033	33.7%	16,641	64.1%	8,777	36.8%	37,701	66.2%	18,273	32.6%
NEW MEXICO	663	64.4%	329	29.8%	2 081	66.5%	648	31.8%	8 879	66.7%	6 648	30.3%
NEW YORK	14,831	68.8%	9,717	31.1%	42 784	66.0%	29,117	32.0%	68,633	70.6%	40 009	29.6%
NORTH CAROLINA	3 333	73.8%	1,337	37.1%	10,126	71.2%	4,104	28.8%	24 878	72.7%	8 348	27.3%
NORTH DAKOTA	450	66.2%	230	33.8%	1,148	64.3%	640	34.6%	2 322	66.6%	1,225	34.4%
OHIO	7,872	64.0%	4,313	36.0%	20 106	63.6%	11,413	36.1%	62,184	66.0%	33 899	34.0%
OKLAHOMA	1,965	72.8%	700	29.1%	6,096	73.1%	1,876	26.9%	11,818	74.3%	3 843	26.6%
OREGON	1 606	66.2%	880	34.6%	4 842	64.6%	2,964	36.6%	11,034	66.3%	5,871	33.6%
PENNSYLVANIA	8 108	60.4%	4 961	34.9%	21 834	63.0%	13,700	37.0%	48 956	60.1%	24 678	34.8%
RHODE ISLAND	886	64.5%	388	35.5%	3 060	64.3%	1,187	35.7%	6,706	66.0%	2 452	34.0%
SOUTH CAROLINA	1,905	74.5%	550	29.6%	4 614	72.3%	1,844	27.7%	11,999	73.9%	4 130	26.1%
SOUTH DAKOTA	430	66.0%	183	31.0%	1,118	66.3%	666	34.7%	2 370	66.7%	1,186	33.3%
TENNESSEE	2 562	63.7%	1,472	36.3%	7 132	61.6%	4,402	36.2%	18 126	61.8%	10 065	36.5%
TEXAS	9 818	72.2%	3 810	27.8%	26,778	66.5%	13 818	30.8%	71,496	70.6%	29 636	26.4%
UTAH	726	69.2%	324	30.8%	2 052	64.6%	1,234	35.4%	6 536	66.4%	2 903	33.6%
VERMONT	292	67.8%	136	33.8%	904	66.2%	463	34.8%	2 061	67.0%	1,012	33.0%
VIRGINIA	2,554	70.2%	1,176	34.8%	11,264	73.9%	3,966	26.2%	27,995	75.6%	8 995	24.4%
WASHINGTON	2,802	66.3%	1,348	33.7%	8,094	63.7%	4,616	36.2%	18 094	66.6%	8 864	24.4%
WEST VIRGINIA	1,186	71.8%	456	29.2%	2,678	67.6%	1,236	32.4%	5,241	66.3%	2,432	31.7%
WISCONSIN	3,343	66.8%	1,784	34.3%	8,829	63.6%	6 002	36.2%	19 786	66.9%	8,741	34.1%
WYOMING	267	66.2%	118	30.8%	660	66.2%	344	34.3%	1,490	67.7%	706	32.2%

* Health payments cover the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. Each includes government public health expenditures the administrative costs of public programs, and the net cost of private insurance. We have excluded from this presentation non-patient revenues, research and construction

** Families are groups of one or more persons related by birth, marriage or adoption and who are residing together. Parents and adult children residing with other family members are counted as separate units

PREPARED STATEMENT OF JOHN ROTHER

Good morning. My name is John Rother. I am Director of Legislation and Public Policy for the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today, to help the Committee and the public clearly identify the problems in our health care system and the dire consequences of failing to enact comprehensive health care reform legislation.

As a membership organization of 33 million Americans, AARP has a great interest in the national health care debate. Over the past few years, we have listened very closely to what our members and their families want in a health care system. We hope to serve as a voice for average Americans, young and old, who fear falling into one of the many gaps in the current health care system and who are looking for broader protections against the high costs of health and long-term care.

My testimony today is part of our effort to highlight the substantial costs of doing nothing, and to identify some very disturbing trends that deteriorate coverage and access to health care and lead to higher costs.

Changing Course Before It's Too Late

Most Americans enjoy the benefit of high-quality health care, bolstered by state-of-the-art technology and top-notch physicians and hospitals. In fact, the state of medical care in the United States is clearly of equal or better quality than most other nations in the world. Yet, within this success are the seeds of the system's failure—a failure to provide American families adequate access to the system and protection against the high costs of care.You don't have to look far to see that current health care trends foretell a clouded future without comprehensive reform. Spiraling costs and inadequate coverage will mean more cost-shifting, higher costs and lower benefits for families, and continued lack of protection against the enormous costs of longterm care.

The attached 13 charts—all using data from respected research efforts—paint a bleak picture for health care in the United States in the absence of comprehensive health care reform. They portray gaps that already exist and could get much worse if nothing is done.

Chart 1: Without health care reform, your family's payment for the Nation's health care bill will grow

In 1993, national health expenditures are estimated to be $903 billion, or 14.4 percent of GDP. In the absence of health care reform, by the year 2000, total health spending will reach $1.7 billion—18.1 percent of GDP. On this projection, the Congressional Budget Office and the Health Care Financing Administration agree. In more personal terms, the average health care bill attributable to each family (i.e., household) will increase from $9,377 in 1993 to $16,984 in the year 2000.[1 & 2]

Chart 2: Hidden costs are a major share of the average family's health care bill in 1993

Americans are increasingly aware of the high health care costs paid directly out of their pockets. These payments include health insurance premiums, copayments, deductibles, and bills for uncovered services. However, they may not be aware of all the other larger, yet hidden, ways that families pay for this country's health care. Only about one-third of per-household health care spending in 1993 is for costs that are "visible" to consumers. Families pay the vast majority of their health care bill—roughly two-thirds or $6,292 in 1993—through "hidden" costs such as lower wages because an employer has to spend more on health insurance premiums and the higher prices paid for products as a result of the rising health care costs for manufacturers. Health care

[1] Burner S. T., Waldo D.R., and McKusick D.R. "National Health Expenditure Projections Through 2030." Health Care Financing Review, Fall 1992, Vol. 1 4, No. 1.

[2] U.S. Department of Commerce Bureau of the Census - "Projections of the Number of Households and Families: 1986 to 2000." Current Population Reoorts, Series P-25, No. 986.

costs for government health programs, such as Medicare and Medicaid, are also hidden in state, local and federal taxes that are paid.[3]

No one is suggesting that the hidden costs should be shifted to individual families; the direct burden would be too great. In fact, the health care burden needs to be shared by employers, federal and state governments, and individuals in an equitable and progressive manner. However, a better understanding of the "whole picture" in health care is essential to public willingness to support reform.

Chart 3: Without reform, rising costs will take three more weeks of your family's income

If families could spend less of their time working to cover health care costs and more of it on earning money to spend in other ways, would they do it? Chart 3 shows that U.S. health care costs are already so high that over two months' worth of income per household is spent on health care. In fact, in 1993, health care costs ate up all income from January 1 through March 18, or 77 days' worth. Unless Congress and the President enact comprehensive health care reform, an additional three weeks of household income will be lost to health care costs by the year 2000. Households won't finish paying their health care bill until April 6, accounting for nearly 100 days worth of household income.[4]

Viewed in another way, health care reform could provide American families with the opportunity to "refinance" their health care costs at much lower rates than today's. This would free up money for other uses.

High health care costs are a major factor in why so many families don't have coverage or have inadequate coverage—and this vicious cycle is likely to get much worse.

Chart 4: Without health care reform, what is you risk of being uninsured for an entire year in the future?

The statistic of 37 million uninsured has achieved such common usage that it takes on a quality of "otherness." The myth is that those "other" 37 million people are quite distinct from the 212 million Americans with good health coverage. It is often thought that we should help this uninsured group out of a sense of charity, but that the middle class is protected from this fate. The reality is quite different. Lack of adequate health coverage is both much more pervasive and much less monolithic.

In 1991, the U.S. Census Bureau found that 36.3 million people, or 16.6 percent of the non-elderly, were uninsured for the entire year.[5] The risk of being uninsured is greatest for unemployed, less educated, low-income and single parent families, but the prospect of losing coverage threatens the security of all groups. Fdr example, the risk of not being insured is:

– 1 in 3, if you are employed by a firm with less than 10 employees;

– 1 in 4, if you are single without children;

– 1 in 7, if you are age 30-54;

– 1 in 8, if your head of family works full-time, full-year;

– 1 in 9 if you are a professional services worker; and

– 1 in 10 if you are employed by a large firm.

[3] U.S. Department of Health and Human Services, HHS News, January 29, 1993; Cowan, C.A. and McDonnel, P.A. HBu5iness Households and Governments—Health Spending, 1991. Report of HCFA Office of the Actuary; Burner S.T., Waldo D.R., and McKusick D.R. "National Health Expenditure Projections Through 2030." Health Care Financing Review, Fall 1992, Vol. 14, No. 1.

[4] U.S. Department of Commerce, Bureau of the Census. "Measuring the Effect of Benefits and Taxes on Income and Poverty: 1979-1991." Current Population Reports, Series P-60, No. 182-RD; Laurence H. Meyer & Associates, Ltd. "Long-Term U.S. Economic Outlook, June 15, 1993; Burner S. T., Waldo D.R., and McKusick D.R. "National Health Expenditure Projections Through 2030." Health Care Financing Review, Fall 1992, Vol. 14, No. 1.

[5] Bureau of the Census, Health Insurance Coverage: 1987-1990, May, 1992.

Chart 5: Without reform, you are at risk of being without health insurance for at least one month...even if you think you're not

Many families manage to patch together coverage most of the time but find themselves without insurance for one or more months of the year. Twenty-six percent, more than 1 in 4 Americans, did not have health insurance for at least one month between February, 1987, and May, 1989.[6]

One month without coverage may not seem like a long period of time. Families can sometimes get by when they lose a month's worth of income or when a worker becomes unemployed. But lack of health insurance is quite different. During one month without health insurance, a woman might discover breast cancer, or fail to discover it because she could not afford the office visit or diagnostic tests. A man might be stricken with a heart attack or stroke. A child could become seriously ill or injured. The month without insurance then becomes several months or even years during which a family cannot buy coverage because an employer or insurance company refuses to cover preexisting conditions. Without coverage, a family faces medical bills that could jeopardize the family's economic security for years to come.

Chart 6: Lack of health coverage affects more than money: you face a risk of death 25% higher if you are uninsured than if you are insured

Many of the uninsured do get health care, but they typically get it through the back door of the health care system after substantial waiting and on an emergency basis. As a result, the uninsured are at a greater risk of getting inadequate care and dying. A recent study published in the Journal of American Medical Associations (JAM A) concluded that the lack of health insurance placed an individual at a 25 percent greater risk of subsequent mortality. Researchers found that the lack of health insurance over a long period of time often correlated with a decrease in access and a lower quality of care. Additionally, individuals lacking insurance often did not seek medical care until their condition was critical. Such conditions have led to a higher death rate among the uninsured.[7]

Chart 7: Without health care reform, employees can expect to pay more in the future for their health benefits and/or receive less in coverage

Over the years, most working families have been able to secure coverage through their employers, moderating the impact of rising health costs. This trend has slowed in the past few years and may have reversed as employers are resorting more and more to approaches that shift the costs to workers and/or dilute benefits.

A national poll of business executives conducted in July, 1993 by *Business & Health* magazine found that 90 percent of employers surveyed—up from 76 percent in 1992— would increase their employees' share of premiums as costs rise. Additionally, 40 percent of those surveyed—up from just 16 percent in 1992— would cut their employees' medical benefits.[8]

Chart 8: Without health care reform, employees can expect to have their choice of health care plans restricted as employers respond to rising costs

The same *Business & Health* survey found that 31 percent of executives would drop traditional insurance and offer only managed care plans, up from only 22 percent in 1992. Without a fee-for-service option, workers must often choose between only two or three plans—each with a limited choice of providers. In some cases, longstanding physician-patient relationships are severed or workers must choose to pay entirely out of their own pockets to maintain continuity of care.

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[6] Bureau of the Census, Health Insurance Coverage: 1987-1990, May, 1992.

[7] Franks P., Clancy C.M., Gold M.R., "Health Insurance and Mortality", JAMA, August, 1993.

[8] Business & Health, The Annual National Executive Poll on Health Care Costs and Benefits, July, 1993.

Chart 9: Without reform that includes long-term care, any member of your family may face uncovered expenses due to disability

To a family sitting around the kitchen table, there is only one, critical difference between a $30,000 hospital bill and a $30,000 nursing home bill—more often than not, the hospital bill is covered by insurance while the family must pay 100% of the cost of nursing home care.

Generally, when one thinks of long-term care, nursing homes filled with disabled senior citizens is the image that comes to mind. In fact, individuals of any age can find themselves in need of long-term care services at any time. What is little known is that the largest number of individuals who are limited in their ability to perform major activities in their daily lives and may need long-term care either at home or in a nursing home, fall between the ages of 45 and 64. The 1990 National Health Interview Survey found that 7.5 million individuals between the ages of 45 and 64 may need long-term care services, compared to 6.6 million over the age of 65, 6.5 million between the ages of 18 and 44, and 2.3 million children.[9]

Chart 10: Without reform that includes comprehensive long-term care, 43% of older people face substantial out-of-pocket costs due to nursing home stays

Today, a one-year stay in a nursing home cost an average of $30,000 and as high as $60,000 in some states. Although 43 percent of those over the age of 65 will use a nursing home at some point in their lives, few will be able to pay for it. A relatively small percentage of individuals have private long-term care insurance, and for those who do, it is expensive and yields few benefits. Medicare offers very little in the way of nursing home benefits, covering only post-hospital stays of limited time. And, while Medicaid covers nursing home stays for those who cannot afford to pay, it has strict eligibility criteria that require individuals to exhaust most assets and virtually all income.[10]

Chart 11: Without health care reform, prescription drug prices—which more than doubled in the 1980s—could double again

Many families, particularly older Americans, cannot afford high prescription drug prices and are too frequently denied access to essential, often life-saving, medications. The Pharmaceutical Manufacturers Association estimates that 72 million Americans lack health insurance for prescription drugs. Older Americans rely more on medications to maintain their health but have substantially less coverage than other age groups. Since Medicare does not cover prescription drugs, out-of-pocket costs are significantly higher for older Americans than for their younger counterparts. Substantial increases in drug prices over the past twelve years have meant forced choices between paying for medications or other necessities.

Between 1980 and 1992, prescription drug prices rose by 188 percent, nearly three times the increase in general inflation and even more than medical inflation. Without health care reform that includes enforceable cost containment, drug prices will continue to rise at unaffordable rates in the 1990s.

Chart 12: Without health care reform, cuts in only public programs lead to higher charges for privately insured patients

Out of frustration over the budget deficit, Congress has in the past cut public health insurance programs—Medicare and Medicaid—without limiting the explosive growth in the rest of the health care system. Such a lopsided approach doesn't solve the health care cost problem; it simply exacerbates it. In 1991, Medicare hospital payment rates were only 68 % of what private insurance paid, and Medicaid paid even less. When there are no system-wide limits, hospitals, physicians, and other providers

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[9] 1990 National Health Interview Survey, p. 108.

[10] Kemper, P., and Murtaugh, C. M., "Lifetime Use of Nursing Home Care", The New England Journal of Medicine, February 28, 1991.

simply charge private insurance patients more. Employers and workers alike pay what could be considered a health cost-shifting "tax" that increases each time Medicare and Medicaid rates are cut. In its June 1993 report, CBO found that between 1985 and 1991 total per-capita health spending—largely paid by private insurance—grew at a rate 50 % higher than per-capita Medicare spending.[11]

Chart 13: Without health care reform, cuts in only public programs affect patient access to physician services

The growing gap—almost a gulf—between private insurance payments and Medicare and Medicaid rates also affects patient access to care. There is mounting evidence that more and more physicians are reluctant to take new Medicare patients because Medicare only pays 65 cents for every dollar that private insurance would pay. Medicaid access is worse still as physicians receive only 55 cents for every private-pay dollar.[12]

What We Mean By "Comprehensive" Health Care Reform

If the picture of the current health care system is a bleak one, what can the Congress and President do to make the future look brighter and more secure for American families? Comprehensive health care reform will require leadership on the part of the federal government and a willingness to make tough decisions on behalf of the American people. At a minimum comprehensive reform means:

- -- A federal guarantee that all Americans have access to affordable, high-quality health and long-term care;
- -- System-wide cost containment that eliminates cost-shifting and slows the explosive growth in health spending;
- -- Comprehensive benefits that include prevention, physical and mental health care, home and community-based care and nursing home care;
- -- Health delivery system reforms that reduce access problems in underserved areas and reward efficient, high-quality care; and
- -- Fair and affordable financing of the new health care system, so that government, employers, and individuals all pay their share and everyone is protected against the high costs of care.

AARP's specific plan for comprehensive health care reform, "Health Care America," was developed with the extensive involvement of AARP members and leaders across the country. Its centerpiece is a strengthened and expanded Medicare program through which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care benefits. Employers would be required to pay for at least 80 percent of their workers' benefits, either through the public program or through the same or better private coverage. In addition to ensuring access, the system would continue to foster choice, diversity, and innovation in the delivery of health services. The system would be accountable to consumers through a new Federal Health Care Commission that would set spending targets and establish other rules.

"Health Care America" is a proposal that offers hope and security to all individuals, young and old. AARP recognizes, however, that there are many paths to the this goal. We will use Health Care America as a standard against which to measure the effectiveness of other health care reform proposals and as a "compass" to guide the Association's participation in the health care reform debate.

The Association is pleased with the leadership demonstrated by the President and his Administration and looks forward to the impending announcement of his plan. We are also pleased with the Joint Economic Committee's interest in this issue. Over the

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[11] Congressional Budget Office, Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift"?, May, 1993.

[12] Physician Payment Review Commission, Optional Payment Rates For Physicians: An Analysis of Section 402 of H.R. 3626.

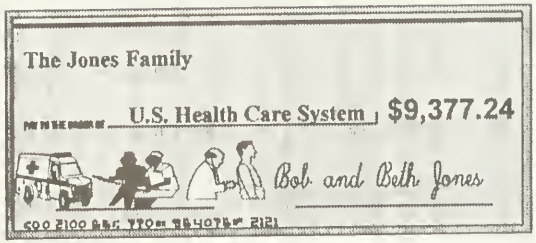
next few months, AARP will engage our members in a national debate on health care reform and work toward enactment of federal legislation in this Congress.

Health care reform truly is an issue whose time has come. We need to proceed expeditiously toward eliminating the gaps in the current health care system and providing security for American families. But more importantly, we need to do it right. Reform must be comprehensive or it simply won't work.

Thank you for the opportunity to testify today. I welcome any questions the Committee might have.

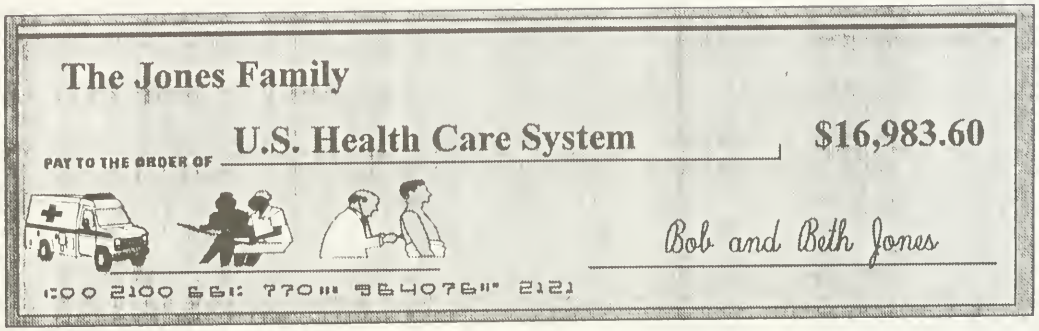
Chart 1

Without health care reform, your family's payment for the nation's health care bill will grow.



1993

2000



Prepared by AARP Public Policy Institute
SOURCE: HCFA and Bureau of Census. Figures are averages based on total national health expenditures

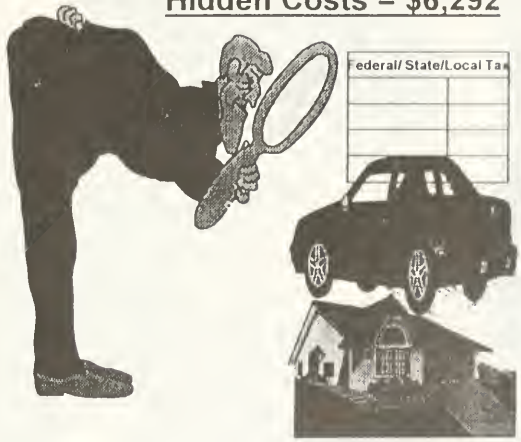
Chart 2

Hidden costs are a major share of the average family's health care bill in 1993.

Visible Costs = $3,085

Deductibles and coinsurance
Uncovered services and goods (e.g., long term care, prescription drugs, mental health)
Consumer health insurance premiums
Specific taxes (Medicare Part A)

Hidden Costs = $6,292

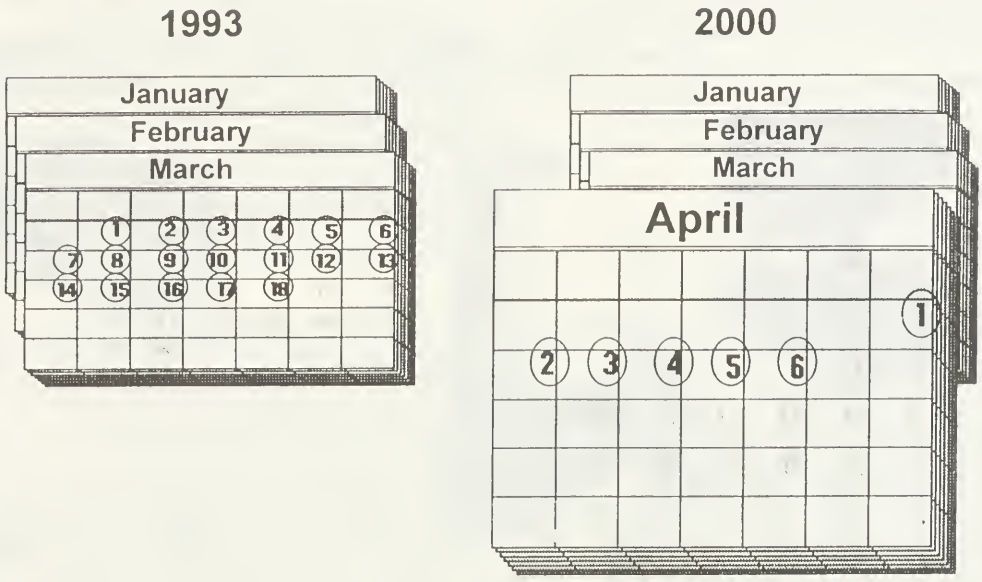


Higher product prices (e.g., automobiles, groceries)
Lower wages due to employer contributions
General taxes (e.g., property, sales, income) for public programs (e.g., Medicare Part B, Medicaid, government hospitals)

Prepared by AARP Public Policy Institute
SOURCE HCFA , HHS, and Bureau of Census Figures are averages based on total national health expenditures

Chart 3

Without reform, rising health care costs will take three more weeks of your family's income.



Prepared by AARP Public Policy Institute
SOURCES: HCFA, Bureau of Census, and Laurence Meyer Associates
Figures are averages based on total national health expenditures

Chart 4

Without health care reform, what is your risk of being uninsured for an entire year in the future?

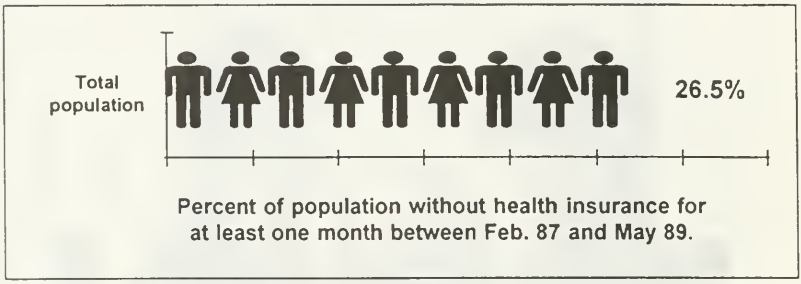
1 in 4, if you are single without children.
1 in 7, if you are age 30-54.
1 in 8, if your head of family works full-time, full-year.
1 in 9, if you are a professional services worker.
1 in 10, if you are employed by a large firm.

Without reform, no one is protected from being uninsured.

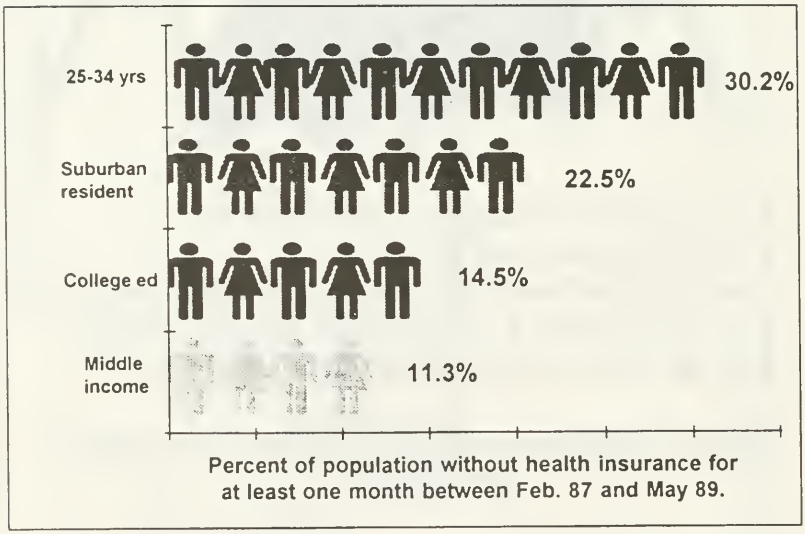
Prepared by AARP Public Policy Institute
SOURCE Employee Benefit Research Institute. 1993 Data are for 1991

Chart 5

Without health care reform, you are at risk of being without health insurance for at least one month. . .



. . . even if you think you're not!



Prepared by AARP Public Policy Institute
SOURCE Bureau of the Census

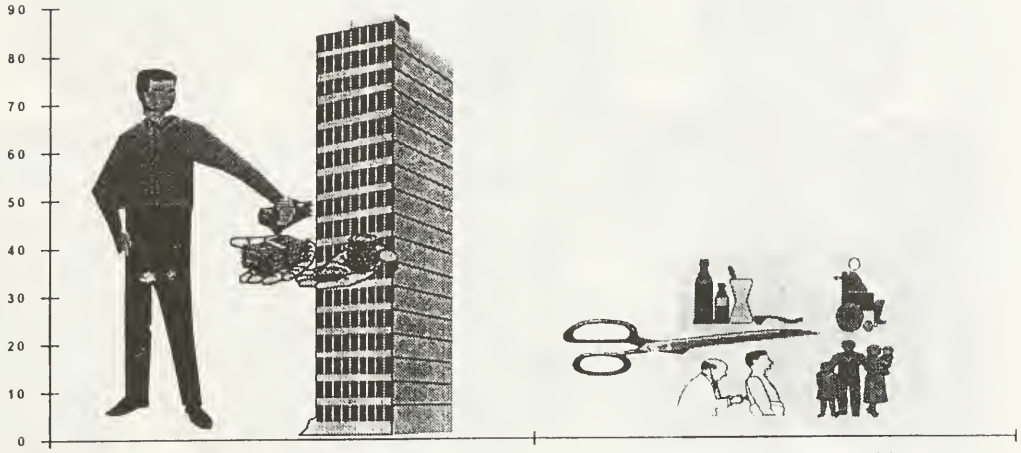
Chart 6

Lack of health coverage affects more than money: you face a risk of death 25% higher if you are uninsured than if you are insured.

Prepared by AARP Public Policy Institute
SOURCE: Analysis of National Health and Nutrition Examination Survey as presented in JAMA, Aug. 11, 1993.

Chart 7

Without health care reform, employees can expect to pay more in the future for their health benefits and/or receive less in coverage.



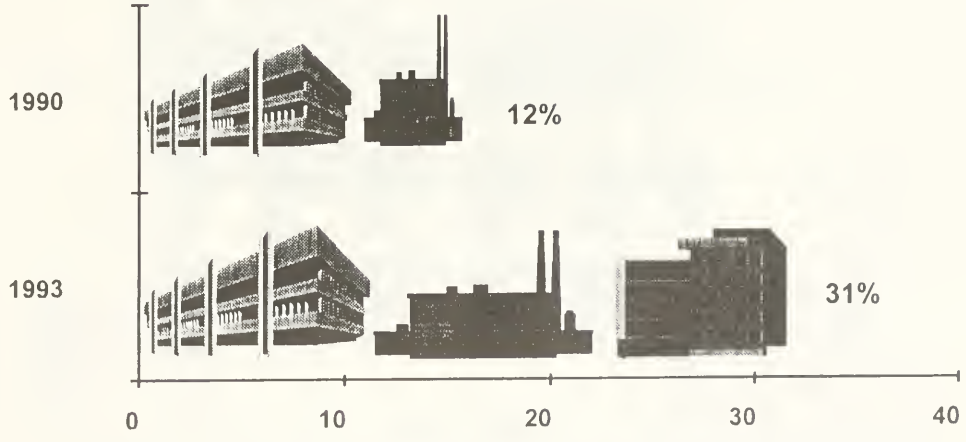
90% of employers would increase employee share of premiums.

40% of employers would cut employees' medical benefits

Prepared by AARP Public Policy Institute
SOURCE Annual National Executive Poll as presented in Business & Health, July 1993

Chart 8

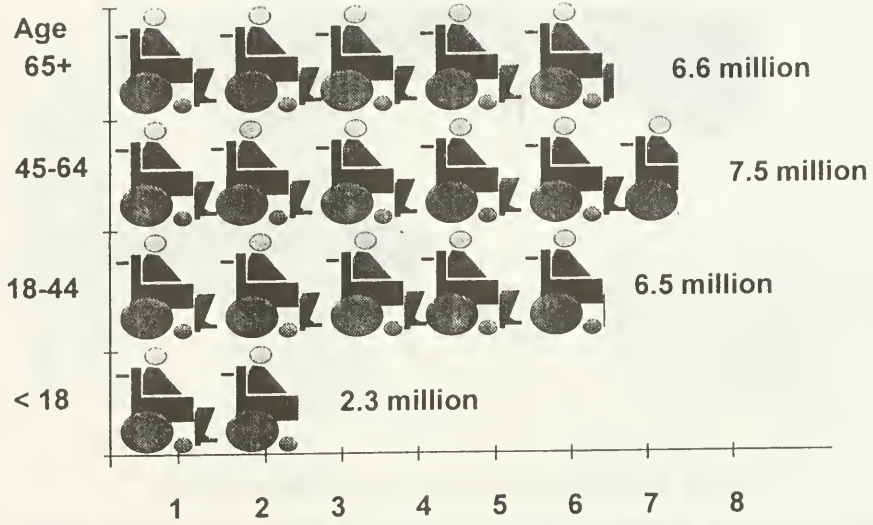
Without health care reform, employees can expect to have their choice of health care plans restricted as employers respond to rising costs.



Prepared by AARP Public Policy Institute
SOURCE. Annual National Executive Poll as presented in Business & Health, July 1993 and April 1990

Chart 9

Without reform that includes long-term care, any member of your family may face uncovered expenses due to disability.



Prepared by AARP Public Policy Institute
SOURCE: 1990 National Health Interview Survey

Chart 10

Without reform that includes comprehensive long-term care, 43% of older people face substantial out-of-pocket costs due to nursing home stays.

43% of 65-year-olds will use nursing homes during their lifetimes.

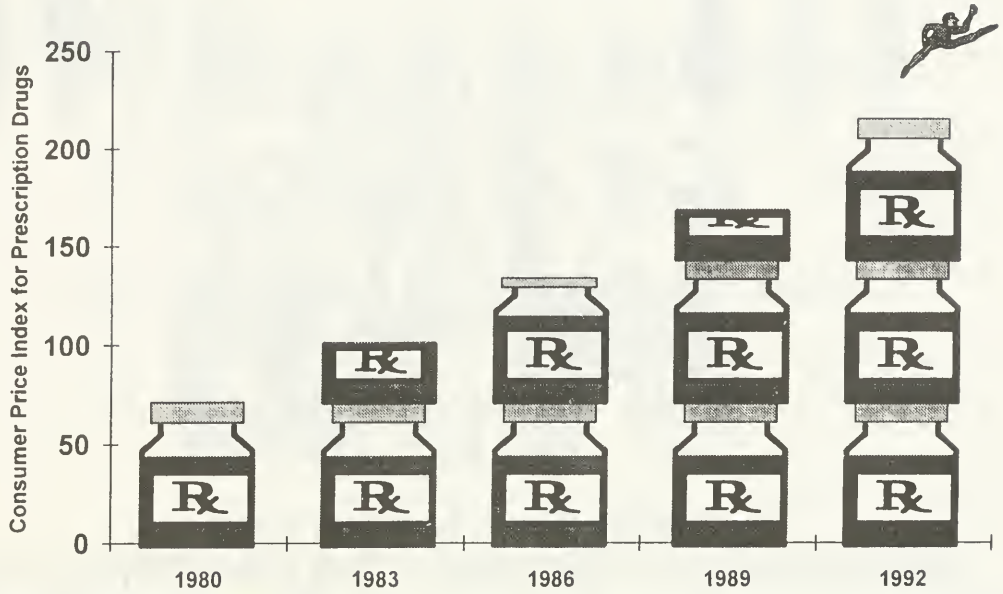
1 out of 2 65-year-old women will use nursing homes during their lifetimes.

1 out of 3 65-year-old men will use nursing homes during their lifetimes.

Prepared by AARP Public Policy Institute
SOURCE: 1990 projections based on 1986 National Mortality Followback Survey as presented in NEJM, Feb 28, 1991

Chart 11

Without health care reform, prescription drug prices--which more than doubled in the 1980s--could double again.



Prepared by AARP Public Policy Institute
SOURCE. U S Bureau of Labor Statistics

Chart 12

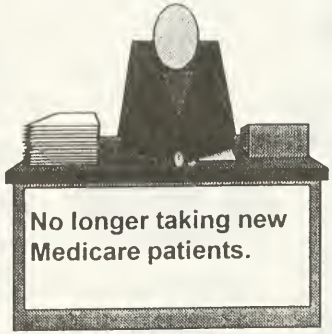
Without health care reform, cuts in only public programs lead to higher charges for privately insured patients

When Medicare pays less.....private patients pay more.

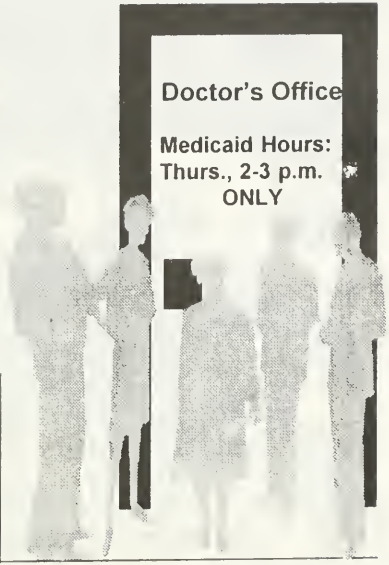
Prepared by AARP Public Policy Institute
SOURCE Congressional Budget Office Data are for 1991

Without health care reform, cuts in only public programs affect patient access to physician services.

Doctors receive highest payments from privately insured patients.



Doctors receive 35% less from Medicare.

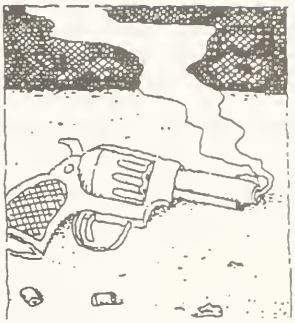


Doctors receive 45% less from Medicaid.

Prepared by AARP Public Policy Institute
SOURCE: PPRC. Data are projections for 1994

Social Problems That Escalate America's Health Care Costs

LEROY L. SCHWARTZ, MD,
and
MARK W. STANTON



Americans should not be too quick to trade in their health-care system for a foreign model. Critics attack the system for its excessive cost and its failure in providing a sizable segment of the American population with access to quality care, but the system is getting more than its fair share of the blame for these problems. There is a major reason underlying the higher cost of American health care: A significant number of Americans exhibit excessive rates of illness and death. since the demand for change is driven by our rapidly rising health care costs, much of the debate has centered simply around the economics of who should pay the bill—government, the private sector or a combination of the two.

TAILORED TO U.S. NEEDS

Some policymakers and advocates hope to address this cost concern by adopting a government-run, national health insurance program—similar to Canada's or Germany's—thus radically changing our health-care system. The Canadian example of a single-payer system, a model that is popular in America, has its own problems with the cost and provision of care. It is the second most expensive system in the industrialized world, although it should be cheaper, because it services a young population and has global budgets for hospitals, constraints on high and low technology, waiting lists for various procedures, and fee schedules for doctors and other professionals. Any discussion of a Canadian-style system for this country must address this question: Why is Canadian health care so expensive? Simply adopting a foreign system will not solve America's health-care dilemma. The uniqueness and complexity of American society and its special requirements demand a health-care system that must be tailored to our needs.

The United States has a society that includes around 50 million people living in poverty. While most of these people are white, many of the poor are minorities—especailly black, Hispanic and Native Americans. In addition, a large number of Americans exhibit certain behavioral risk factors contributing to severe health problems. Although many of these people receive care, it is frequently late in the illness, in the emergency room, and, therefore, much more expensive. Social pathologies such as the breakdown of the family structure, chronic unemployment, poverty, homelessness, substance abuse, violence and despair wind up in the emergency rooms, intensive care units and morgues of our hospitals. American's many social problems —poor housing and overcrowding with a resulting high rate of tuberculosis (TB); drug abuse leading to its own pathology, in addition to violence and sexually transmitted diseases (STDs); high-risk pregnancies leading to premature births, infant morbidity and mortality; and alcoholism leading to cirrhosis and other illnesses —contribute not only to the higher cost of care in this country but also to certain relatively poor gross measures of health, such as our infant mortality and life expectancy rates. As mentioned above, this additional pathology is a result of poverty compounded by certain destructive behaviors found in this country. In other words, our severe

If Canada, Germany or Sweden had our social problems, a comparable poor population and behavioral risk factors, their sickness and death rates surely would be much worse and their health care costs would be much higher.

social problems are paid for once they become medical problems.

The incidence of extremely premature infants with low birthweight—frequently related to socioeconomic conditions and certain behavioral risk factors—is considerably higher in the United States than in other developed countries. Our health-care system has been particularly responsive to this problem, and the recent decline in our infant mortality can be attributed largely to improved survival rates of these babies and other small infants whose lives are saved primarily because of more neonatal intensive care programs. However, this use of high technology is extremely expensive—costing an estimated $2.6 billion annually—and this figure does not include the long-term, frequently lifelong costs of caring for those with residual disabilities.

EXPENSIVE PROBLEMS

- There are many other illustrations of expensive health problems related to behavioral factors occurring more frequently in the United States, especially among the poor and minority groups:

- Unintentional injuries are widespread in this country compared with other developed countries and are a leading cause of death among our children and young persons, particularly those in minority groups. A recent Rand Corporation report indicated that the medical and other direct costs of injuries represented about $90 billion of the $176 billion that accidents cost annually.

- Physicians and nurses, particularly in emergency rooms, constantly treat an array of victims of violence. There are more than 20,000 homicides in the U.S. annually. The male homicide rate in the U.S. is 10 times the male homicide rate of Britain and Germany and four times that of Canada. An indication of the immensity of the health-care problem—as depicted in one study—is that for every homicide, 50 victims of crime receive care in the emergency room or hospital. Spinal cord injuries illustrate the financial implications: More than 25 percent of these injuries—about 45,000 people—result from violent assaults. The lifetime cost of quadriplegia treatment, for example, can be as high as $600,000 per person.

- Drug abuse and unsafe sex are associated with the estimated 1 million to 1.5 million persons infected with the HIV virus. As of January 1990, there were 118,000 AIDS cases in the U.S.—four times the Canadian rate—costing some $75,000 per person for lifetime treatment, or about $8.85 billion, including large research outlays.

- There are up to 375,000 drug-exposed babies born each year in this country. The treatment of these infants is $63,000 per baby for the first five years of life alone, or about $23.6 billion.

- Pelvic inflammatory disease (PID), an infection of the female upper reproductive tract, affects from 10 to 15 percent of women of reproductive age in the U.S., according to a recent National Institutes of Health report. Up to 1 million new cases are added annually. Most cases of PID are caused by sexually transmitted organisms and are related to such preventable sexual practices at first intercourse at a young age, a frequency of sexual intercourse and multiple sexual partners. Treating PID cost this country about $3.5 billion in 1990 and that is expected to rise to $8 billion annually during the next 10 years.

- In addition, TB, an infectious disease previously thought to be under control, is reappearing in a new drug-resistant strain and increasing at a rapid rate in our poor population, especially among substance abusers and persons with AIDS. From 1989 to 1990 the number of TB cases increased 9.4 percent—the largest rate of increase since 1953. More than 25,000 new cases were reported in 1990. In certain

While the evidence is tentative, it does suggest that although Americans are paying more for health care, we may indeed be getting more.

states the rate of increase is much higher. For example, in New Jersey, the TB caseload increased by 36 percent during the last five years.

EFFECT ON HEALTH CARE COSTS

If Canada, Germany or Sweden had our social problems, a comparable poor population and behavioral risk factors, their sickness and death rates surely would be much worse and their health-care costs would be much higher. Those who propose national health insurance as the answer to the rise in health-care costs and the problem of access many find that unless we are able to reduce the amount of care required in this country, the result may be large-scale rationing. Thus, the commonly cited differences between U.S. and foreign health-care costs may have less to do with out different health-care systems than with our widely divergent populations.

Nevertheless, evidence is emerging that despite the flood of illness resulting from our poverty and behavioral risk factors, our health-care system is performing better than is generally understood. A closer examination of our infant mortality rate indicates that this country saves relatively more babies with low birthweight and babies from age one month to one year —probably through the application of intensive medical care and high-cost technology—than do other highly industrialized countries. Sweden, for example, has made the societal decision to withhold treatment, with the effect that some infants die who otherwise might have survived.

In addition, there is evidence that for many conditions amenable to medical or surgical interventions such as cancer, heart attacks and enlarged prostate, U.S. death rates are frequently lower than those of the countries with which we are generally compared, particularly for populations over the age of 50. (Infant mortality and life expectancy, which generally are used as measures of quality of a health-care system, are much more dependent upon social factors.) Other countries' higher death rates may be related to the long waiting lists found in a number of health systems administered by governments, which could postpone or deny people lifesaving medical and surgical care. This particularly would be a problem in the U.S., where our poverty and behavioral risk factors tend to compound the well-known tendency of poor and minority patients to put off seeking preventive and curative care. While the evidence is tentative, it does suggest that although Americans are paying more for health care, we may indeed be getting more. Given the nature of the issue, extensive new research is needed.

Finally, recent surveys indicate that Americans overwhelmingly consider the health care they receive to be of good quality, but they are dissatisfied with its sharply rising cost and the inadequate protection afforded by our health insurance schemes. Thus, any changes in our health-care system should carefully retain its quality aspects, offer adequate financial protection, maintain public satisfaction, provide a high level of care and preserve the excellence of our medical research. This can be achieved if the U.S. makes the commitment to resolve our social problems *before* they become medical problems—at the same time, innovatively addressing our present, vast health-care needs. Only then can we avoid rationing health care to the poor, the elderly and the middle class—a characteristic of many health-care models some people suggest we adopt.

The real challenge to our policymakers is not to ration care to save money, as other countries often do, but to extend American health care, research and technology—frequently the best in the world—to the remainder of our population, including the poor, at an acceptable cost. For while there is little doubt that the U.S. health-care system needs improvement and can be improved without destroying its excellence, it is likely that our pluralistic approach is best suited to a pluralistic America.

LEROY L. SCHWARTZ, MD, (left), a pediatrician is president and MARK W. STANTON, MA, is vice president of Health Policy International, a non-profit corporation in Princeton, N.J.

The American Health Care Dilemma: Social Factors

PREPARED STATEMENT OF SARA ROSENBAUM

Mr. Chairman and Members of this Committee;

Thank you for providing me with this opportunity to appear before you today, as you explore the considerable dimensions of the nation's health care crisis. As you start deliberations over one of the most vital pieces of social welfare legislation to emerge in the past 30 years, you are to be commended for beginning the process by considering the lives of the real families who will be affected by your decisions.

Prior to coming to the George Washington University, I spent nearly 20 years representing families who needed health care and could not get it. I have practiced in both urban and rural communities, as well as in Washington, D.C. My work on health care has ranged from efforts to improve access to prenatal care and childhood immunizations to advocacy for improved conditions for elderly nursing home residents.

What has struck me most over the years care is the fragile nature of the system on which we all depend. Many of my clients fit the classic description of persons who are likely to be affected by the gaps and holes in the current system: poor young families working at low paying jobs that carry virtually no fringe benefits. But in fact, many of the families whose problems I have worked on come from the world that, I would venture to say, we in this room inhabit: affluent families who have virtually no sense of their vulnerability until disaster strikes.

The families I have represented have had terrible problems. What makes these problems even more disturbing is their commonality. Each of the cases I describe is one that each Committee member recognizes as all too common. These situations all have confronted your families and friends, as well as countless constituents without regard to family income or place of residence:

- the affluent family who experienced the birth of a child with a catastrophic condition that in a single year consumed all of the health insurance to which the baby was entitled over a lifetime;
- the worker earning good pay at a good job who overnight watched his whole life fall apart when he developed leukemia and could no longer work;
- the well-paid worker with four children, one with juvenile diabetes, laid off following a plant closure and unable to find work that carried <u>any</u> insurance, much less insurance that would accept the child with a pre-existing condition;
- the healthy pregnant accountant who experienced a stroke during labor and delivery and who required months in a rehabilitation hospital for which she was completely uninsured, because of limitations in her insurance plan;
- the parents of a brilliant and beautiful girl who in her freshman year in college developed schizophrenia and has required hundreds of thousands of dollars in uncovered institutionalization;
- the 60 year old retired couple living on an annual income of $22,000 who have watched their subsidized retiree health benefits—costing some $600 per month— disappear as a result of a company cutback in benefits promised to them as part of a long-term compensation package;
- the father of twins born with Downs syndrome who were forced out of his small law firm's health insurance plan. In his case, the insurer threatened to raise premiums one hundred percent for the other members of the firm and their families if the babies were not removed from the policy. The insurance actuaries asserted that, despite a complete lack of evidence, the babies at some point in the future <u>might</u> experience greater medical risks because of their Downs syndrome. Every other insurer turned the family down because of the babies' pre-existing condition.
- the working mother—a secretary of three —who called me at work last week to ask my advice. She wanted to know if I thought it was too risky for her to stop

paying for health insurance coverage for her two young children. Her company provides workers with a 50 percent contribution toward their monthly insurance premiums but nothing for dependents. Her husband had abandoned her, leaving her with a $350 monthly dependent premium bill to pay, out of take-home pay of $1400 per month for herself, her two children, and her 76-year-old mother.

These are the families I have represented. They are the families we all know, and they are the families who could be any one of us if the stars line up badly one day. For a half century we have depended on a voluntary, loosely structured (some would say unstructured) health care system in which coverage is jury-rigged by employers and employees and is supplemented by a chaotic framework of inadequate federal and state programs that mostly miss the mark.

Now that system is collapsing in the face of costs so high that led to a one-third increase in the number of uninsured persons even during a decade of overall economic growth. A million people a year are losing coverage. Wage earners cannot change jobs for fear that they and their families will be left uninsured or only partially covered. Even routine health care needs—checkups and immunizations for their children and the normal assortment of family health problems—can cost thousands of dollars. A real illness without adequate insurance is simply unthinkable for any of us.

I ask that, as you consider approaches to solving the nation's health care crisis, you bear in mind that the following facts represent real people:

- One in five privately insured Americans—30 million—will lose coverage at least once during the next 32 months. More than a third of these will be children. Only two thirds will get their coverage back. More than 40 percent of those losing insurance will be uninsured for at least five months or more.[1]
- In 1990, only 43 percent of all construction firms (7 percent of the labor force) offered health insurance. Only 55 percent of manufacturing firms and 32 percent of retail trade firms offered coverage.[2]
- Nearly 10 million children—over 15 percent of all children—have at least one health condition requiring additional health care and treatment.[3]
- Between 1977 and 1987 the proportion of children with private health insurance declined from 73 percent to 63 percent. Had it not been for the Medicaid, over 20 million American children—one third of all children—would have been uninsured in 1990. [4]
- Non-poor white Americans have a one-in-eight probability of developing a chronic condition that limits normal daily activity.[5]
- The probability that a male worker between the ages of 20 and 60 will be come either temporarily or permanently disabled from a work-related illness or injury is nearly one in five.[6]
- In 1989 almost 35 million persons—14 percent of the non-institutionalized civilian population—suffered an activity limitation.[7]

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[1] Alan Monheit and Claudia Shur, "The Dynamics of Health Insurance Loss: A Tale of Two Cohorts" Inquiry 25:315-27 (Fall, 1988).

[2] HIAA, Source Book of Health Insurance Data 1991, (Washington, D.C.) p. 13

[3] United States Congress, Office of Technology Assessment, Does Health Insurance Make a Difference? (Washington, D.C., 1992).

[4] Sara Rosenbaum, Dana Hughes, Phyllis Harris and Joseph Liu, Children and Health Insurance (Children's Defense Fund, Washington, D.C. 1992). pp. 7 and 15.

[5] GAO, Workers At Risk (March, 1991)

[6] HIAA, op. cit. at p. 95.

[7] GAO, op. cit.

- 65 percent of conventional health insurance plans and 61 percent of prepaid plans have pre-existing condition limitations or exclusions.[8]
- Two thirds of the uninsured population are in families with full-time, steadily employed persons.[9]
- 12 percent of uninsured persons with at least one limitation in activities were actually denied private insurance because of medical underwriting.[10]
- 15 percent of small firms are routinely "redlined". The redlined industries include firms with older work forces, those employing seasonal workers, workers facing hazardous conditions and hair salons and barber shops.[11]

As you consider national health reform proposals, here are fundamental questions to ask yourselves:

1. Are premiums affordable? This is an issue with respect to both workers and those who do not work, including disabled and laid off workers and early retirees. The method of financing which Congress selects needs to keep contribution levels manageable for both individuals and employers.
2. Is the system of coverage portable? If families change jobs, is there interruption in their benefits? Does a move to a different state lead to coverage disruption?
3. Are preexisting condition limitations and medical underwriting prohibited?
4. Must insurers accept all enrollees without regard to health status?
5. Is there complete protection against the loss of benefits in the face of job layoff or illness? Are early retirees provided for through continuous premium assistance?
6. Is the benefit coverage comprehensive? Are both preventive and primary care benefits as well as long term and chronic health care needs covered, either through the basic insurance plan or through supplemental financing mechanisms?
7. Is coverage of preventive health care complete? This includes at a minimum, prenatal care, well child care, immunizations throughout childhood and adulthood, routine health exams, family planning and reproductive health care, and dental care and vision care.
8. Is cost-sharing kept to a minimum and limited only to care that is neither preventive nor urgent in nature?
9. Is choice of health care providers assured?
10. Are there funds for the development of primary health care services for medically underserved populations? This can be done through investments in programs such as community health centers and other community based clinical programs and the National Health Service Corps, as well as through practice development and support assistance (such as low cost grants and loans and preferred payment rates) for private medical practices located in medically underserved areas.

I am happy to answer any questions.

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[8] HIAA, op. cit.

[9] U.S. Bipartisan Commission on Health Care, A Call for Action (Washington, D.C., 1990).

[10] Kathryn M. Beauregard, "Persons Denied Private Health Insurance Due o Poor Health" ACHPR/NMES Survey data

[11] Wendy Zellers, Catherine McLaughlin, Kevin Frick, "Small Business: Only the Healthy Need Apply" Health Affairs (Spring, 1992).

PREPARED STATEMENT OF MARILYN MOON

I am pleased to be here today to testify on the pressures facing American families because of rising health care costs and increasing insecurity of insurance protection. To characterize the problems we face as a crisis is appropriate; the problems with our health care system are mounting and all those who pay for care—employers, government, and individuals—are facing increasingly difficult choices.

My testimony today will stress two points: first, rhetoric aside, the rapidly rising burdens of health care spending are fully borne—in the end—by American families, and second, the status quo is becoming increasingly insecure, in part because the rising costs of health care and the availability of insurance are inextricably linked.

The Burdens of Health Care Spending

National spending on health care has risen steadily in the United States. Health expenditures are projected to reach $940 billion in 1993, up from $423 billion in 1985 and just $43 billion in 1965. This spending has grown dramatically as a share of gross domestic product as well. Projections that it will account for more than one in every six dollars of gross domestic product (GDP) by the end of the decade have helped to underscore the urgency of the debate on health care reform.

A generation ago, health care spending constituted a much smaller share of family budgets, on average, and hence was not nearly as much of an issue. Families spent, on average, $370 in 1963 and spending per person averaged $112.[1] Translated to 1991 dollars, this represented expenditures of $498 per capita. These expenditures totaled just 3.8 percent of median income.[2]

But health expenditures began to rise dramatically in the 1970s for all Americans. Between 1970 and 1991, per capita spending more than doubled (after controlling for inflation) from $1,160 to $2,518. By 1991, health spending on behalf of individuals represented 17.2 percent of median income. Projecting this forward to 1993, per capita spending is likely to be about $3,050 and account for approximately 19.5 percent of median income.[2]

We know that individuals do not directly pay for all of these expenses. Employers, by providing insurance to their employees, pay a substantial share of health care--about 29 percent in 1990. And government now accounts for about 42 percent of health care spending. As a consequence, individuals' spending out-of-pocket for health care not covered by insurance totaled $550 in 1991, or 3.8 percent of 1991 per capita median income. (This percentage is thus the same as the share of spending from all sources in 1963.)

If contributions to insurance premiums and Medicare taxes are added to this total, individuals' contributions rise by another $355 to $905. This raises the burden of health spending to 6.2 percent of per capita median income. By this year, this amount has likely risen to $1100, or 7 percent of median income. This 7 percent is the average burden that most Americans would recognize as their "share" of health care spending. (This impact would also vary substantially across families depending upon income and other characteristics. Lower income individuals, for example, bear greater proportional burdens than the population as a whole.)

But it is misleading to argue that individuals pay only for their out-of-pocket expenses and any required insurance contributions. In practice, taxpayers foot the bill for government programs, and households indirectly pay for employers' share either through lower wages (the most likely way that costs are shifted onto individuals), higher prices of goods and services, and/or lower profits. These "invisible" costs of

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[1] The per capita figures used here are more consistent through time since family size and composition has changed.

[2] Median income is used here because the distribution of income tends to be more skewed than health expenditures. Consequently, dividing average health spending by median income tends to give a share closer to what would be obtained if each individual's own spending and income were compared.

health care are larger than the visible ones—likely totaling about $1950 per capita in 1993—and we should always be cognizant of them as well. One way or another, these large total health care costs—averaging $3050 per capita in 1993—are borne by American households. Increasing costs of health care reduce all of our abilities to consume other goods and services.

Nonetheless, government and employer-subsidized insurance still play an important role, not in lowering overall costs but in spreading the risks and burdens of extraordinary costs. Insurance means that charges to individuals are limited by the pooling of risk so that burdens are averaged. The potential burdens for those without insurance are much greater; such persons are vulnerable to catastrophic expenses and are likely, on average, to bear a disproportionate burden of health care spending.

Further, even though care is available to persons who lack insurance, recent studies have demonstrated that those with insurance coverage are likely to be better off in terms of both the quantity and quality of care they receive. Health outcomes for persons without insurance suffer as compared to those who have private coverage.

The Insecurity of the Status Quo

Americans fear for the future of their health insurance coverage. For example, many Americans voice concerns about changing jobs in this uncertain environment, and express fears of retaining quality coverage even if they do not shift employment. Increasingly, the statistics on the availability of health insurance coverage indicate that such fears are legitimate.

Over 35 million Americans under the age of 65 lacked health insurance in March of 1992. Those most likely to be totally without public or private insurance are young adults (age 18 to 24), persons with incomes below poverty (because of the inadequacy of Medicaid), and minorities. But perhaps of most interest, nearly three-quarters of all the uninsured are either employed or are dependents of employed persons. And over half (53 percent) of the uninsured are in families with one or more full-time workers.

While the aggregate numbers of the uninsured have remained relatively constant for some time, the make-up of this group is changing. Increasingly, the uninsured are in the labor force; our employer-based system is allowing many American workers to fall through the cracks. For example, analysis by one of my colleagues, Colin Winterbottom, shows that between 1988 and 1991, employer-sponsored insurance fell from covering 66.8 percent of the nonelderly population to 64. 1 percent. The difference was made up by an increase in Medicaid coverage—rising from 8.5 percent to 10.7 percent of the nonelderly. These findings are consistent with an earlier study by the Employee Benefit Research Institute which found that employer and union-sponsored coverage peaked in 1981 and has been falling since that time.

Insurance industry data also confirm a decline in coverage. Between 1989 and 1991, the proportion of firms with under 25 workers offering insurance coverage declined from 39 to 32 percent. And for slightly larger firms (with 25 to 99 workers), the percentage fell from 93 to 81. Smaller firms tend to have lower average wages—making it relatively expensive to offer insurance—and to experience a more difficult time in obtaining affordable coverage.

In addition to reductions in coverage, many other aspects of employer-provided insurance are also changing. Utilization management activities (such as pre-admission certification and case management for large claims or mental health services) are now the exception and not the rule for most employer-sponsored plans. And increasingly employers are opting to place their workers in managed care arrangements—often with little choice available to workers. In 1981, just one of every 13 persons in the U.S. were enrolled in managed care.[3] By 1991—just 10 years later, the figure is one in every two persons in employer-sponsored plans. And the pace of change has been picking up. For example, the share of employer-sponsored enrollees in HMOs rose from 20 to 25 percent just between 1990 and 1991.

[3] Included in managed care are health maintenance organizations (HMOs), preferred provider organizations and other entities that seek to coordinate and oversee the delivery of health care.

Over time, employees are being asked to bear a greater portion of the costs. Most plans now require deductibles and copayments from enrollees. These increasing restrictions and concerns about exclusion of coverage for certain diseases or problems make even workers whose employers offer insurance feel less secure.

The consequences of this greater insecurity extend beyond higher cost sharing and more financial risk, however. Disparities in health care coverage may discourage workers from changing jobs. Several new studies indicate that the increasing disparity across employers in availability and comprehensiveness of insurance result in "job lock." For example, employees with alternative sources of insurance coverage are about 25 percent more likely to change jobs than those who must rely upon their own employer's insurance. Distortions in labor force mobility because of these differences may result in lower incomes over time for families when their options are restricted, higher costs for business, and subsequently lower overall economic growth as well.

The Link Between Health Care Costs and Access to Care

It is not a coincidence that reductions in employer-sponsored coverage were coming during a period of rapidly rising costs. Throughout the 1980s, as health care costs spiraled upward, employer-sponsored coverage fell and employers undertook major cost containment efforts. Between 1965 and 1990, business spending on health care rose from 2 percent of total compensation to 7.1 percent. Thus, even if wages did not increase at all, employers' costs for compensation more than tripled in order to keep providing health insurance. Just for the period 1988 to 1991, employer-sponsored health insurance costs rose 75 percent (in nominal terms) as compared to an increase in average weekly earnings of 16.7 percent. As costs increase, employers become less willing to offer coverage, resulting in a worsening of the problem of insurance protection for Americans.

Moreover, the increasing efforts by business and government to hold down spending on health care has put additional pressures on those who lack insurance and must depend instead on free care provided by physicians and hospitals. Pressures on providers to reduce costs and offer discounts are ever more frequent, in turn reducing the flexibility of providers to pay for charity care. And Medicare, responsible for about a fourth of health care spending in the United States, has held down its rates of reimbursement as well. Unless there is substantial change, the future portends more of the same, likely resulting in an even more unsatisfactory and unstable system.

In the future, higher costs are also likely to translate into higher insecurity and disruption of our economy.

Conclusion

Each year, families have less and less to lose from a change in our current health care system. Higher costs make both individuals and employers less tolerant with the system we now have. Thus, arguments that we should go slow with health care reform so as not to upset the status quo are overstated. The status quo is changing very rapidly in the United States and our firm foundation of employer-sponsored insurance is increasingly being weakened. The "status quo" of the future may be even less generous or secure.

What if there is no reform? If there is no national reform, many of the problems that are helping to spur change will likely worsen and the patchwork response of our health care system will leave increasing gaps in protection for families. Medicare and Medicaid will likely continue to be subject to stringent cost cutting of the type we have seen in recent years. Private employers will also likely keep up the pressures to reduce costs. Without a rational health care system, we should expect to see an even more confusing and restrictive patchwork of efforts to hold down costs by shifting them on to other payers or by limiting access to care.

A consistent, national effort to bring the system under control is likely to be more in the interests of everyone—patients, providers and payers. What is not known is whether we will indeed see a resolution of these problems in the near future.

PREPARED STATEMENT OF DEBORAH CHOLLET

Summary

Employer-sponsored health insurance plans are the single largest source of private insurance coverage among nonelderly Americans. In 1991, 140 million Americans under age 65—including nearly 89 million workers—had coverage from an employer-sponsored health plan. Approximately three-quarters of employer-insured workers are covered as a benefit of their own employment; all others—some 21 million workers —are covered as the dependent of an employer-insured worker.

The number of American workers covered by an employer health plan has declined over the last decade. Historically, during periods of economic recession, the number and proportion of workers without employer-sponsored coverage has risen. However, at least since the 1984 recession, economic recovery has failed to produce recovery of employer-sponsored health insurance among employed workers and their dependents. Between 1985 and 1991, the number of jobs that provided health insurance fell by nearly 2 percent: 1.2 million fewer workers were covered as a benefit of their own employment in 1991 than had been covered six years earlier. Since 1988, the loss of employer-insured jobs has accelerated.

The erosion of coverage from employer-sponsored plans coincides with major changes in the structure of the U.S. work force. The loss of manufacturing jobs and the expansion of service jobs and part-time employment have both contributed to a decline in the rate of employer-sponsored health insurance among employed workers. Not only does manufacturing provide more of its own workers with coverage compared to other industry groups, but manufacturing also is a significant net "exporter" of coverage to dependent workers in other industries. In 1991, the net export of coverage to other industries represented a 20-percent tax on manufacturing employers per own-covered worker. In contrast, professional services—the fastest-growing industry group—collected a subsidy from other industry groups equal to more than 12 percent per own-covered worker.

Only the expansion of Medicaid coverage—covering pregnant women and children to 133 percent of the federal poverty level—has offset the erosion of employer-based coverage among workers and their families. In 1991, more than 12 million workers and their dependents were covered by Medicaid; of these, at least one-third (4.5 million persons) lived in families headed by full-time full-year workers. It is likely that ongoing expansions of Medicaid for pregnant women and children in many states since 1991 (to 185 percent of poverty or more) have further increased the number of Americans in families of low-wage workers who rely on Medicaid to finance health care since 1991.

The changing structure of American jobs suggests that employer-based coverage has probably continued to erode. Since January 1993, manufacturing employment declined by an estimated 125,000 jobs. Continuing increases in the cost of health care relative to all other goods and services imply a growing burden for employers that maintain their health insurance benefits for workers.

In recent years, many states have undertaken private insurance reforms to reduce the variation in health insurance costs among small businesses and individuals, discouraging or prohibiting insurers from "churning" their business in that market. In most states, however, these reforms have not addressed the underlying trend of health care costs. Consequently, the average cost of health insurance for all employers has continued to rise much faster than increases in consumer prices and employee wages. Without aggressive action to curb the cost of health care, there is no reason to believe that competitive pressure to reduce or eliminate health insurance benefits among workers has eased, nor that the rate of employer-sponsored insurance coverage among workers and their dependents will recover.

Introduction

Employer-sponsored health insurance plans are the single largest source of private insurance coverage among nonelderly Americans. In 1991, 140 million Americans under age 65—including nearly 89 million workers—had coverage from an employer-sponsored health plan. Approximately three-quarters of employer-insured workers are covered as a benefit of their own employment; all others—some 21 million workers—are covered as the dependent of an employer-insured worker.

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The erosion of coverage from employer-sponsored plans coincides with major changes in the structure of the U.S. work force. The loss of manufacturing jobs characterized by relatively high rates of employer-sponsored coverage, and the expansion of service jobs and part-time employment have both contributed to a decline in the rate of employer-sponsored health insurance among employed workers.

The following sections describe the economic burden of employer-sponsored health insurance coverage assumed by employers and workers in different industries and different-sized firms. Estimates of uninsured workers and employer-insured workers are presented, as well as estimates of the net change in employer-insured jobs within major industry groups relative to the change in industry employment. These estimates indicate that the growth of employer-insured jobs has been consistently slower than employment growth in industries that have experienced net job growth. In industries where employment has declined, employer-insured jobs have declined even faster.

1. Uninsured and employer-insured workers

The fact that rates of uninsured workers vary widely among industry groups and firm sizes is well known. However, these differences in rates of uninsured workers mask even greater variation in the underlying structure of workers' insurance coverage within industry and firm size groups. These underlying differences are briefly described below in terms of the coverage that is provided directly from the employer as an employee benefit (employer-insured jobs) and coverage that workers receive from sources other than their own employment—principally employer-based coverage received by workers as dependents of another worker's plan and Medicaid coverage of low-income workers as they qualify within federal- and state-defined eligibility categories.

Variation by industry group. In 1991, the proportion of workers who were uninsured from any source throughout the year (or for a significant proportion of the year) varied markedly among industry groups. Nearly 42 percent of agricultural workers reported having no insurance coverage of any kind during the year (see Table 1; Figure 1). Among workers principally employed in construction and personal/entertainment services, nearly 30 percent were uninsured all year. These very high rates of uninsured workers contrast with very low rates of uninsured workers in other major industry groups, especially in government (7 percent uninsured) and in finance, insurance and real estate (8 percent uninsured).

In general, industries with low rates of uninsured workers have relatively high rates of employer coverage, either sponsored by the workers' own employers or received as a dependent of another worker. Other sources of coverage—individually purchased insurance and Medicaid—generally represent much smaller sources of coverage among all workers, regardless of industry.

Differences among industry groups in the rate at which workers are insured by their own employer versus another worker's employer are also substantial, suggesting corresponding variation among industries in the economic burden of health insurance benefits (see Table 2; Figure 2). In 1991, just over one-half of all workers (55 percent) were covered directly by their own employer; all other employer-insured workers were covered only by another worker's plan as a dependent. Nationally, for every 10 workers insured by their own employer, another three workers were covered only as a dependent.

In firms that do not offer a contribution to health coverage, coverage received by workers as dependents of workers in other firms represents "imported" coverage, equivalent to a real subsidy to the dependent workers and to their employer. If wages adjust fully to offset the value of employee benefits, the subsidy is collected in the form of higher wages by workers in firms that do not provide coverage as an employee benefit. If wages do not adjust fully, the value of benefits *not* provided to workers is collected by the firm as greater profit (perhaps supporting an otherwise unprofitable enterprise), or by consumers as lower product prices.

In 1991, the number of wage and salary workers covered only as a dependent per 100 workers covered by their own employer varied from a low of 7 in mining, to 83 in personal and entertainment services (see Table 2). This burden on plans that offer coverage to their own workers represents in effect a "tax" collected by firms and industry groups that import coverage from firms and industries that export coverage. In general, industry groups with relatively high proportions of uninsured workers are also relatively large importers of health insurance coverage, measuring imported coverage as the number of employer-insured workers covered only as a dependent per own-industry worker. Differences among industries in their rate of imported coverage from either other employer plans or Medicaid are illustrated in Figure 3.

Variation by size of firm. The differences in coverage described in the preceding section occur systematically among firms of different sizes, regardless of industry group. Among wage and salary workers who identified firms with fewer than 10 employees as their principal job in 1991, 29 percent reported having no insurance from any source throughout the year (See Figure 4; Table 3). This rate was systematically lower as firm size increased; among wage and salary workers in firms of 1,000 employees or more, only 9 percent reported having no coverage from any source during the year.

Lower rates of uninsured workers in larger firms correspond most obviously to higher rates of employer-based coverage and, in particular, to higher rates of coverage from the workers' own employer. Workers in large firms are substantially more likely than small-firm workers to have coverage sponsored by their own employer (regardless of full-time job status) and less likely to have employer-based coverage only as a dependent of another worker. Among workers in firms of 1,000 or more employees, just 17 workers are covered only as a dependent for every 100 workers covered by their own employer (see Figures 5 and 6). In contrast, for every 100 workers covered by their own employer in firms with fewer than 10 employees, 95 are covered only as the dependent of another worker.

Medicaid. Medicaid is a relatively small but growing source of coverage among low-income workers in the U.S., principally as a result of federal expansions of Medicaid eligibility effective since 1990 and expansions of eligibility in many states in excess of the federally required minimum. At present, all states are required to extend coverage to pregnant women and to infants (to age 1) if their family incomes are less than 133 percent of the federal poverty standard. States may extend eligibility to pregnant women and infants up to 185 percent of poverty with full federal matching, and many have done so. Some states have elected to extend Medicaid to these groups with income as high as 200 percent of poverty. These provisions have resulted in a small but growing number of workers and worker families that qualify for Medicaid. This phenomenon of Medicaid-covered workers may be most apparent in states where wages are relatively low and average worker earnings are nearer to the federal poverty standard.

Rates of Medicaid coverage among workers by industry and by firm size are illustrated in Figures 3 and 6, respectively. While only about 2 percent of American workers reported coverage from Medicaid during 1991, in some industry groups —agriculture, retail trade, business and repair services, and personal and entertainment services—reliance on Medicaid as an exclusive source of health coverage ranged between 4 and 6 percent of total industry employment. Similarly, reliance on Medicaid by workers employed in small firms (4 percent) is greater than that among workers in large firms (2 percent). However, nearly 29 percent of Medicaid-insured workers identified firms with 1,000 employees or more as their principal employer, compared to only 20 percent who identified firms with fewer than 10 employees as their principal employer (see Figure 7). As defined here, these workers reported no coverage from an employer plan (either from their own employer or as a dependent) that year.

2. Growth and loss of employer-insured jobs

Since 1985, net employment in the U.S. has grown 7.4 percent. This aggregate change includes very fast growth in some industries (in professional, and personal and entertainment services, and among self-employed workers) and declining employment in others (manufacturing and mining). As employment has changed among industry groups, so has the proportion of workers that are covered by their own employer. Estimates of the magnitude and direction of these changes are presented in Table 4.

Several aspects of the relative change in employer-covered workers versus the change in industry employment since 1985 are significant. First, industries that have grown most rapidly since 1985 have also gained employer-insured jobs. However, in each of the fast-growing industries, employment growth has substantially exceeded growth of employer-insured jobs. For example, for every 100 jobs gained in the highest-growth industry, professional services, only 67 included health coverage as a benefit (see Table 4, column 4). As a result, while the number of primary-insured workers in high-growth industries has risen, the percentage of all workers in the industry with coverage from their own employer has declined.

Second, with few exceptions, own-employer coverage in moderate-and low-growth industries has declined both absolutely and relative to total employment. Furthermore, industries that experienced the slowest growth in total jobs lost employer-insured jobs the fastest. In very low-growth industries—construction and agriculture—the decline in own-employer jobs has been dramatic, with losses in coverage that are 5 to 125 times the rate of gains in employment.

Finally, industries that have had declining employment since 1985—manufacturing and mining—have lost employer-insured jobs much faster than jobs as a whole. For every 1-percent loss in manufacturing jobs since 1985, employer-insured manufacturing jobs have declined 3 percent. Historically (and in 1991), both manufacturing and mining have had among the highest rates of employer-insured workers compared to other industry groups (see Table 4, column 5).

These changes in the number and rate of employer-insured jobs across sectors suggest that further employment growth is unlikely to stem the dwindling rate of employer-based coverage among workers and their families. Furthermore, the rapid decline of insured jobs in major sectors of the economy may be problematic for other industries. Both mining and manufacturing are relatively small "importers" of coverage from other industries. To the degree that they are also exporters of health coverage to dependent workers in other industries, the faster loss of insured jobs in mining and manufacturing withdraws a real subsidy from other industries and contributes to an ongoing decline in employer-based coverage relative to employment in all sectors.

3. Inter-sector effects of changes in employer-insured jobs

Changes in the structure of employment and primary employer coverage may exert a secondary effect across sectors by changing available sources of insurance coverage for workers whose only coverage is received as a dependent of another worker. This section investigates the potential for that effect by measuring the net export of

insurance coverage from U.S. industries in 1991. In general, declining own-employer coverage in industries that export coverage would suggest a secondary restructuring of employer-based coverage across sectors in addition to the observed changes in own-employer coverage that are occurring within sectors.

Table 5 presents estimates of the net export of insurance coverage to dependent workers in other industry groups (see also Figure 8). These estimates capture only inter-industry export of coverage; inter-firm exports of dependents' coverage also occur systematically by size of firm. Aggregated estimates of net export by firm size (relative to own-employment) are depicted in Figure 9.

The distribution of net health insurance "exports" to dependent workers in other industry groups, presented in Table 5, are significant in several ways. First, industry groups that have gained employment the fastest since 1985 are also among the strongest net importers of dependents coverage from other industry groups, both absolutely and relative to own-industry employment. In 1991, the professional services industry "imported" coverage for 1.2 million workers net of its export of coverage to workers in other industry groups.

Second, the two industry groups that absolutely lost employer-insured jobs between 1985 and 1991, manufacturing and mining, are strong exporters of insurance coverage to workers in other industries. In 1991, manufacturing exported coverage to 3.2 million dependent workers in other industries; these workers were not otherwise covered by an employer plan of their own. On average, for every 100 manufacturing jobs that are lost, a net 15 workers in other industry groups also lose employer-sponsored coverage. The net loss of more than 1 million manufacturing jobs since 1985 has produced an estimated net loss of dependent workers' coverage for at least 157,000 workers employed in other industries. The slow growth of employer-insured jobs in import industries, moreover, seems unlikely to offset inter-industry losses of dependent workers' coverage of this magnitude.

Finally, within industry groups, large firms are by far the greatest net exporters of dependent workers' coverage both absolutely and as a proportion of workers employed in large firms (see Figure 8). In 1991, firms with 1,000 employees or more exported coverage to 4.3 million dependent workers in other-sized firms, net of the coverage that they imported. For every 100 workers employed in large firms in 1991, nearly 10 workers in smaller firms were covered as dependents.

Similar to the net loss of exported coverage associated with the loss of employer-insured jobs in some industries (described above), the down-sizing of large firms in the U.S. has apparently also contributed to the erosion of employer-coverage among both workers and dependents since 1985. Employment growth in small firms—and especially in very small firms—is unlikely to produce offsetting increases in employer coverage for workers and their families. In 1991, small firms—and particularly those with fewer than 25 workers—were strong net importers of insurance coverage both absolutely and relative to their own employment.

4. Export of health insurance benefits as inter-sector taxation

The export of health insurance to dependent workers represents in effect a tax imposed on firms that offer benefits, collected as a subsidy to workers and their employers in firms that do not provide benefits. Estimates of average tax and subsidy rates by industry, per own-insured worker within each industry, are presented in Table 6.

The highest rates of effective taxation on health insurance benefits offered to workers occur in mining (35 percent per own-covered worker) and manufacturing (20 percent), as well as government (23 percent). Mining and manufacturing, in particular, are showing the fastest loss of insured jobs compared to all other industry groups. The greatest rates of subsidy are being collected by firms and workers in personal and entertainment services (72 percent per own-insured worker) and retail trade (35 percent), as well as by self-employed workers (141 percent).

These inter-sector taxes and subsidies are likely to affect the rate of jobs that offer coverage as well as total jobs within industries. High rates of additional cost imposed on mining and manufacturing jobs that are in effect taxed to support dependent workers in other industries discourage the offering of insurance in manufacturing and mining and probably encourage the decline of employment in those industries.

Conversely, high rates of subsidy encourage employment in some industries—including especially services and retail trade. In addition, however, these subsidies discourage employers in those industries from providing insurance benefits to their workers. That is, firms within the industry that *do not* receive subsidies are best able to compete with firms that are subsidized only if they, too, do not offer coverage to their workers. Competition does not allow employers in such an industry to consider whether their workers are covered at all.

5. Concluding remarks

The erosion of employer-sponsored health insurance among American workers and their families is significant. While employment recovered well following the 1984 recession, employer-insured jobs have failed to grow commensurately. Since 1985, 1.2 million employer-insured jobs have disappeared. The single largest factor in the loss of the employer-insured jobs has been the net loss of total employment in manufacturing.

The loss of employer-insured jobs in one sector affects coverage in others as dependents' coverage also is lost. Major industry groups and small and large firms are strongly interdependent, in terms of the dependents' coverage import and export from other sectors. It is notable that the industry groups that have actually lost jobs since 1985, and at an even faster pace lost employer-insured jobs, are also among the strongest net exporters of dependents' coverage to other industry groups. Conversely, the strong import of dependents' coverage by high-growth industries suggests that their growth has been encouraged by the real subsidies provided to their workers in the form of dependents' coverage.

These patterns offer little to support the belief that erosion of employer-based coverage will reverse itself. The extraordinary growth of health care costs—persistently and by wide margins exceeding the growth in prices and wages in all other sectors—implies an increasing burden on businesses that provide health insurance benefits to their workers. As a result, the subsidies provided to other-industry workers in the form of dependents' coverage become ever more burdensome, and the propensity to offer coverage to one's own workers declines.

Aggressive government action to curb the growth of health care costs may stem the further erosion of employer-based coverage among workers and their families. Whether that action would be sufficient to encourage employers voluntarily to offer and subsidize coverage for their workers is less clear. However, failure to act seems virtually certain to encourage continued loss of coverage and a growing sense of crisis among American workers.

Table 1

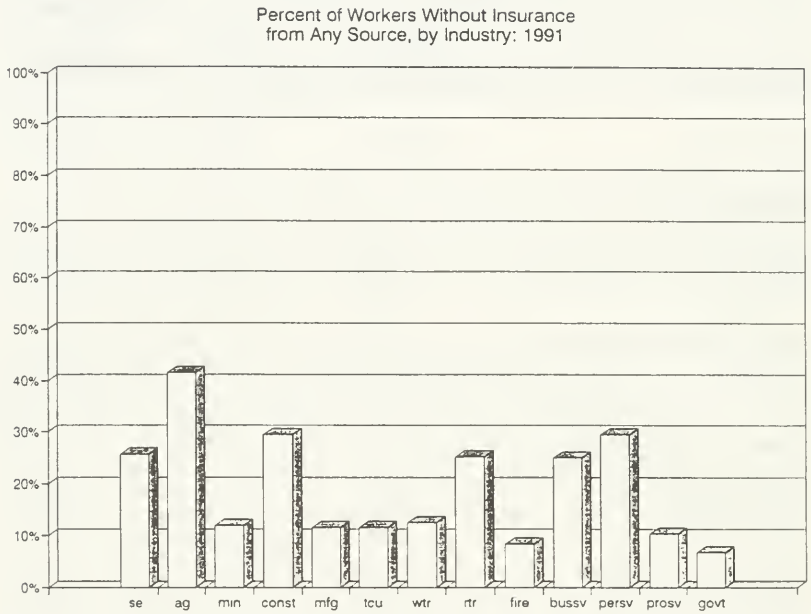
NUMBER OF WORKERS AND RATE OF UNINSURED WORKERS, BY INDUSTRY: 1991

Industry group	Number of workers (in millions)	Workers per U.S. employment	Uninsured workers per industry employment
Total, all workers	123.80	100.0	16.4
High uninsured:			
Agriculture	1.87	1.5	41.6
Construction	6.20	5.0	29.6
Personal and entertainment services	5.35	4.3	29.5
Moderate uninsured:			
Self-employed	9.08	7.3	25.8
Retail trade	19.20	15.5	25.3
Business and repair services	5.83	4.7	25.1
Low uninsured:			
Wholesale trade	4.65	3.8	12.4
Mining	0.75	0.6	11.9
Transportation, communications and utilities	6.72	5.4	11.6
Manufacturing	20.95	16.9	11.5
Professional services	17.07	13.8	10.3
Finance, insurance and real estate	7.24	5.8	8.4
Government	18.90	15.3	6.7

Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 Current Population Survey.

Note: Tabulations include only civilian workers; workers employed in military service are excluded.

Figure 1



Source Center for Risk Management and Insurance Research, Georgia State University, Atlanta Tabulations of the March 1992 CPS

Table 2

PERCENT OF WORKERS WITH EMPLOYER-BASED COVERAGE AND COVERAGE FROM THEIR OWN EMPLOYER, BY INDUSTRY: 1991

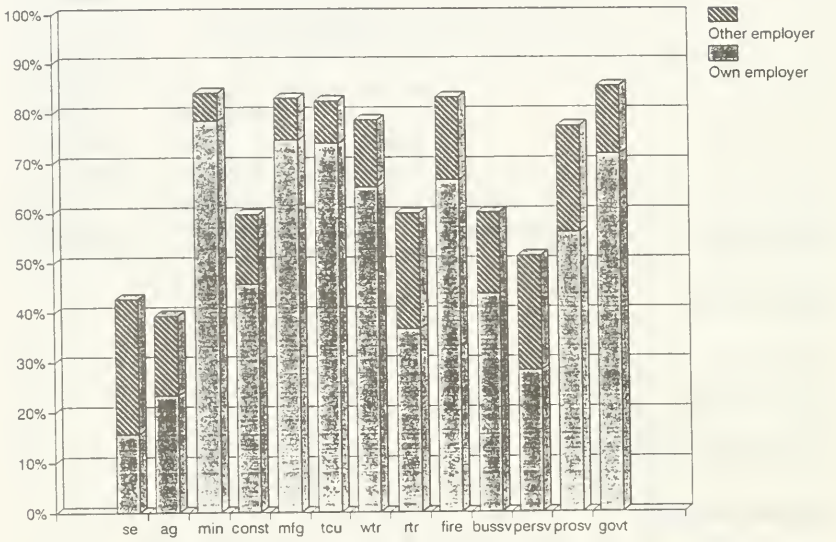
Industry group	Percent uninsured	Employer-insured workers		Ratio: workers covered by other employer per 100 workers covered by own employer
		Total per industry employment	Covered by own employer per industry employment	
High uninsured:				
Agriculture	41.6	39.3	23.2	69
Construction	29.6	59.8	45.6	31
Personal/entert. services	29.5	51.2	28.1	83
Moderate uninsured:				
Self-employed	25.8	42.9	15.6	175
Retail trade	25.3	59.9	36.5	64
Business/repair services	25.1	60.1	43.6	38
Low uninsured:				
Wholesale trade	12.4	78.8	65.2	21
Mining	11.9	84.1	78.4	7
Transp., communications and utilities	11.6	82.5	73.8	12
Manufacturing	11.5	83.1	74.7	11
Professional services	10.3	77.3	55.9	38
Finance, insurance and real estate	8.4	83.2	66.5	25
Government	6.7	85.5	71.7	19

Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 Current Population Survey.

Note: Tabulations include only civilian workers; workers employed in military service are excluded.

Figure 2

Percent of Workers with Employer-Based Health Insurance, by Industry: 1991

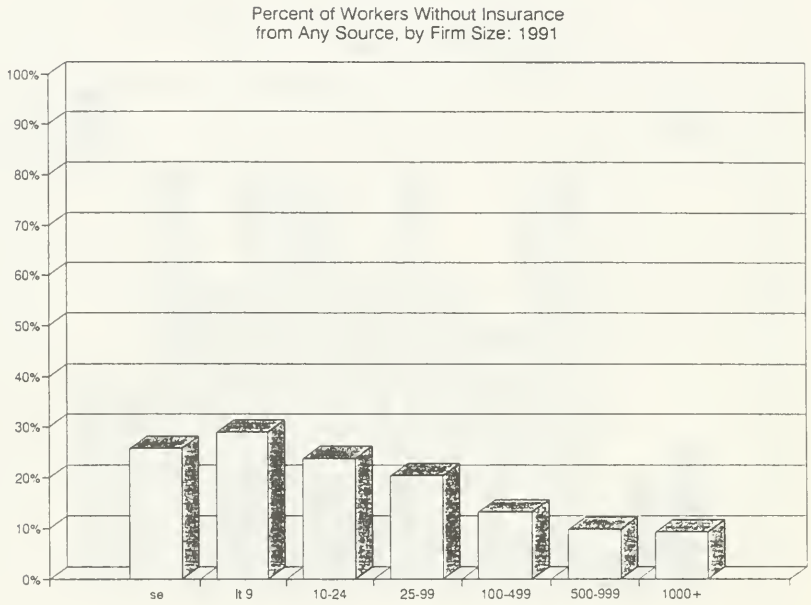


Source Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 CPS

Figure 3

Source Center for Risk Management and Insurance Research, Georgia State University Atlanta. Tabulations of the March 1992 CPS

Figure 4



Source Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 CPS

Table 3

PERCENT OF WORKERS WITHOUT INSURANCE AND WITH EMPLOYER-BASED COVERAGE, BY FIRM SIZE: 1991

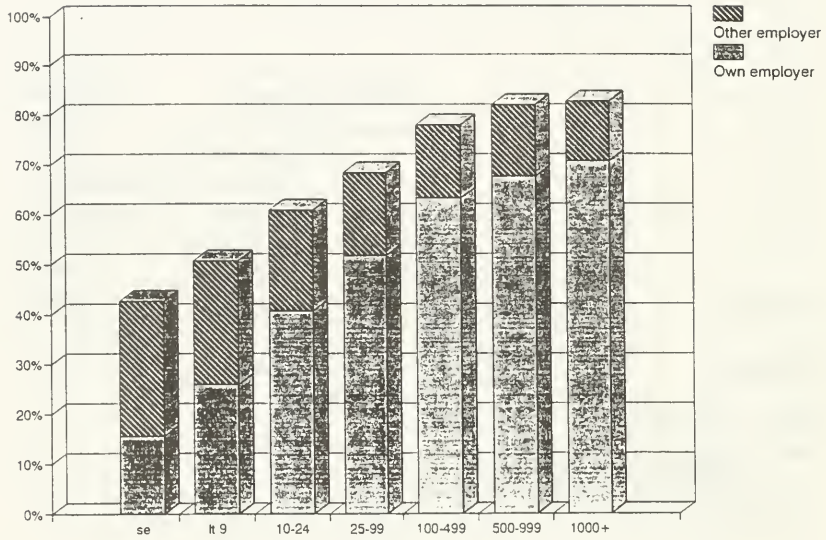
Size of firm	Percent uninsured	Employer-insured		Ratio: workers covered by other employer per 100 workers covered by own employer
		Total per total employment	Covered by own employer per total employment	
Self-employed	25.8	42.8	15.6	175
Wage and salary workers:				
less than 9 ee's	28.9	20.7	23.0	95
10-24 ee's	23.8	61.0	40.6	50
25-99 ee's	20.4	68.5	51.8	32
100-499 ee's	13.2	78.1	63.2	23
500-999 ee's	9.9	82.1	67.7	21
1,000 or more ee's	9.3	83.0	70.8	17

Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 Current Population Survey.

Note: Tabulations include only civilian workers; workers employed in military service are excluded.

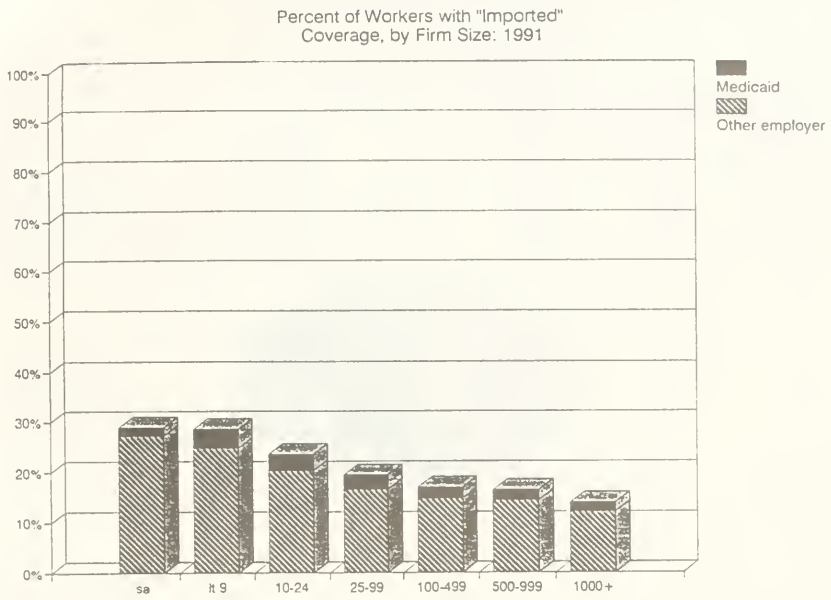
Figure 5

Percent of Workers with Employer-Based Health Insurance, by Firm Size: 1991



Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta Tabulations of the March 1992 CPS.

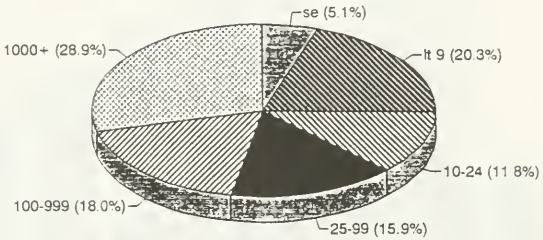
Figure 6



Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 CPS

Figure 7

Percent of Medicaid-Insured Workers
by Firm Size: 1991



Source Center for Risk Management and Insurance Research, Georgia State University, Atlanta Tabulations of the March 1992 CPS

Table 4

CHANGES IN TOTAL EMPLOYMENT AND EMPLOYER-SPONSORED COVERAGE, BY INDUSTRY: 1985-1991

Industry/ employment growth	% change in employ-ment	% change in own-employer coverage	% Change in own employer coverage per % change in employ-ment	Own-employer insured jobs per total, 1991	Other employer insured jobs per total, 1991
Total	7.4	-1.7	-0.24	54.8	16.8
High growth:					
Profssl. services	29.6	19.7	0.67	55.9	21.4
Personal/entertmt. services	13.3	9.5	0.71	28.1	23.2
Self-employed	10.4	4.1	0.40	15.6	27.3
Moderate growth:					
Finance, insurance and real estate	9.2	--	--	66.5	16.6
Transp., commun., and utilities	8.7	0.9	0.11	73.8	8.7
Government	7.8	5.2	0.68	71.7	13.7
Wholesale trade	7.5	-3.9	-0.52	65.2	13.6
Business/repair services	6.9	-6.1	-0.87	43.5	16.6
Retail trade	6.5	-4.1	-0.62	36.5	23.3
Low growth or declining:					
Construction	2.5	-12.6	-5.04	45.6	14.2
Agriculture	0.1	-15.1	-125.89	23.2	16.0
Manufacturing	-4.7	-13.0	2.74	74.7	8.5
Mining	-30.3	-33.7	1.11	78.4	5.7

Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1986 and March 1992 Current Population Surveys.

Note: Tabulations include only civilian workers; workers employed in military service are excluded.

Table 5

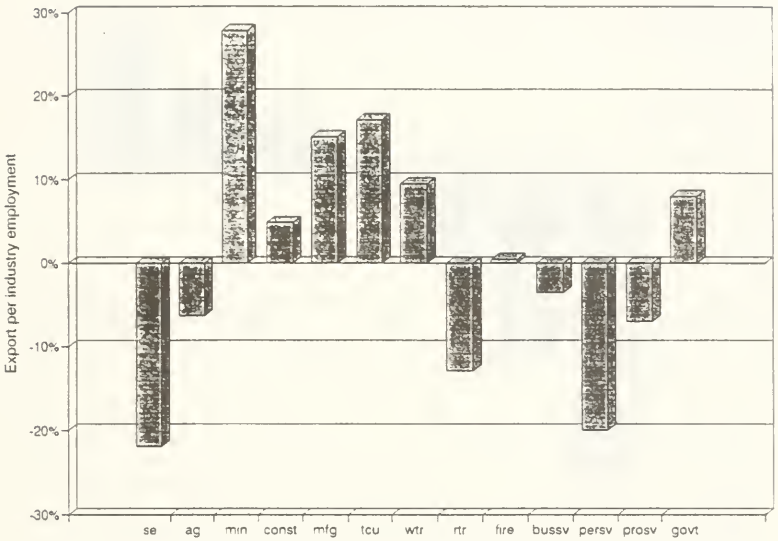
NET EXPORT OF HEALTH INSURANCE TO OTHER-INDUSTRY WORKERS: 1991

Industry/ employment growth	% change in own-employer coverage	Net number of other-industry workers covered as dependents (in millions)	Net number of other-industry workers covered as dependents per own-industry employment in percents)
High growth:			
Profssl. services	19.7	-1.2	-12.5
Personal/entertmt. services	9.5	-1.1	-71.5
Self-employed	4.1	-2.0	-141.1
Moderate growth:			
Finance, insurance and real estate	--	--	0.6
Transportation, communications, and utilities	0.9	1.1	23.2
Government	5.2	1.5	11.1
Wholesale trade	-3.9	0.4	14.5
Business/repair services	-6.1	-0.2	-8.2
Retail trade	-4.1	-2.5	-35.3
Low growth or declining:			
Construction	-12.6	0.3	10.5
Agriculture	-15.1	-0.1	-27.5
Manufacturing	-13.0	3.2	20.2
Mining	-33.7	0.2	35.4

Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1986 and March 1992 Current Population Surveys.
Note: Tabulations include only civilian workers; workers employed in military service are excluded.

Figure 8

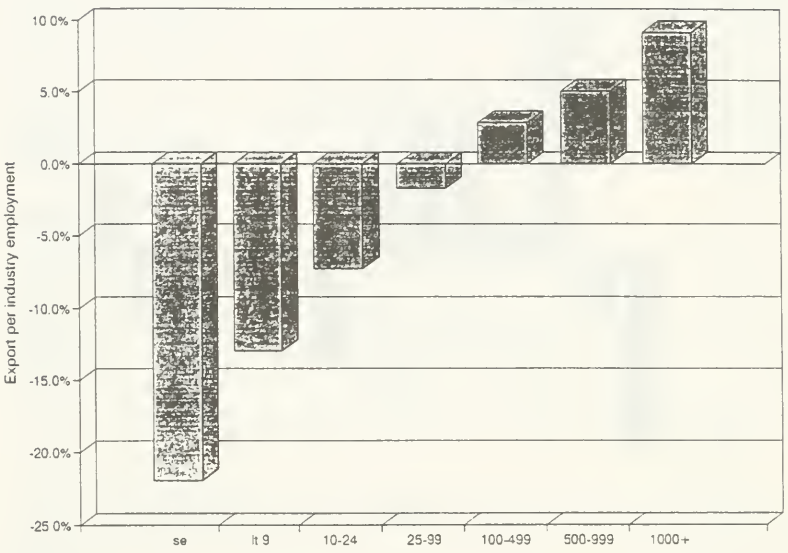
Net Export of Health Insurance Coverage
to Dependent Workers, by Industry: 1991



Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1992 CPS

Figure 9

Net Export of Health Insurance per
Industry Employment, by Firm Size: 1991



Source Center for Risk Management and Insurance Research, Georgia State University, Atlanta Tabulations of the March 1992 CPS

Table 6

ESTIMATED RATE OF TAXATION OR SUBSIDY BY INDUSTRY: 1991

Industry/employment growth	% change in own-employer coverage	Estimated tax (+) or subsidy (-) rate: net number of other-industry workers covered as dependents per own-covered worker (in percents)
High growth:		
Profssl. services	19.7	-12.5
Personal/entertmt. services	9.5	-71.5
Self-employed	4.1	-141.1
Moderate growth:		
Finance, insurance and real estate	--	0.6
Transportation, communications, and utilities	0.9	23.2
Government	5.2	11.1
Wholesale trade	-3.9	14.5
Business/repair services	-6.1	-8.2
Retail trade	-4.1	-35.3
Low growth or declining:		
Construction	-12.6	10.5
Agriculture	-15.1	-27.5
Manufacturing	-13.0	20.2
Mining	-33.7	35.4

Source: Center for Risk Management and Insurance Research, Georgia State University, Atlanta. Tabulations of the March 1986 and March 1992 Current Population Surveys.

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